Im: Rep. Conf. Surg. General with Army Surgeons, 1948, Jan., - - -

DEPARTMENT OF THE ARMY
Office of The Surgeon General
Washington, D. C.

MEDCH/SI U.S. Surgeon-General's Office

13 February 1948

MEMORANDUM FOR

Subject: Report of Conference of The Surgeon General with Army Surgeons and Commanders of Named General Hospitals

1. There is transmitted herewith for your information a copy of the report of the conference of The Surgeon General with army surgeons and commanders of named general hospitals on 15 - 16 January 1948, at The Pentagon, Washington, D. C.

FOR THE SURGEON GENERAL:

H. W. DOAN
Colonel, M. C.
Executive Officer

CONFERENCE OF THE SURGEON GENERAL
with
ARMY SURGEONS AND
COMMANDERS OF NAMED GENERAL HOSPITALS
Washington, D. C.
15 - 16 January 1948

I N D E X

CONFERENCE OF THE SURGEON GENERAL
with
ARMY SURGEONS
and
COMMANDERS OF NAMED GENERAL HOSPITALS
Washington, D. C.

15 - 16 January 1948

The Surgeon General's Conference with Army Surgeons and Commanders of named general hospitals was convened at 0900 hours, 15 January 1948, Room 2C441, The Pentagon, Washington, D. C. The following were present:

OFFICE OF THE SURGEON GENERAL

Major General Raymond W. Bliss, USA
The Surgeon General

Brigadier General George E. Armstrong, USA
Deputy Surgeon General

Colonel Earle Standlee, MC
Deputy for Plans

DEPARTMENT OF THE AIR FORCE

Major General Malcolm C. Grow, USA
The Air Surgeon

ARMY GROUND FORCES

Colonel Frederick A. Blesse, MC
The Ground Surgeon

ARMY SURGEONS

Brigadier General Guy B. Denit, USA
Surgeon, First Army
Governors Island, N. Y.

Colonel George W. Rice, MC
Surgeon, Second Army
Ft. George G. Meade, Md.

Colonel Myron P. Rudolph, MC
Surgeon, Third Army
Ft. McPherson, Ga.

ARMY SURGEONS CONT.

Colonel Robert P. Williams, MC
Surgeon, Fourth Army
Ft. San Houston, Tex.

Colonel Eugene W. Billick, MC
Surgeon, Fifth Army
20 North Wacker Drive
Chicago, Ill.

Colonel Alvin L. Gorby, MC
Surgeon, Sixth Army
The Presidio of San Francisco, Calif.

Colonel Floyd V. Kilgore, MC
Surgeon, Military District of Washington
Washington, D. C.

COMMANDERS OF NAMED GENERAL HOSPITALS

Major General George C. Beach, Jr., USA
Army Medical Center
Washington, D. C.

Major General John H. Willis, USA
Brooke Army Medical Center
Ft. Sam Houston, Tex.

Colonel Harry A. Clark, MC
Murphy General Hospital
Waltham, Mass.

Colonel Leroy D. Soper, MC
Tilton General Hospital
Ft. Dix, N. J.

Colonel David E. Liston, MC
Ft. Totten Army Medical Center
Ft. Totten, N. Y.

Colonel Cleon J. Gentzkow, MC
Valley Forge General Hospital
Phoenixville, Pa.

Colonel Orañel H. Stanley, MC
Oliver General Hospital
Augusta, Ga.

Colonel Asa H. Lehman, MC
Army & Navy General Hospital
Hot Springs, Ark.

COMMANDERS OF ALLIED GENERAL HOSPITALS CONT.

Colonel Paul H. Streit, MC
Brooke General Hospital
Ft. San Houston, Tex.

Colonel George W. Moyer, MC
Wm. Beaumont General Hospital
El Paso, Tex.

Colonel Robert M. Hardaway, MC
Percy Jones General Hospital
Battle Creek, Mich.

Colonel Harry D. Offutt, MC
Percy Jones General Hospital
Battle Creek, Mich.

Colonel Edwin H. Roberts, MC
Percy Jones General Hospital
Battle Creek, Mich.

Brigadier General Omar H. Quade, USA
Fitzsimons General Hospital
Denver, Colo.

Colonel Maxwell G. Keeler, MC
Madigan General Hospital
Tacoma, Wash.

Colonel Dean F. Winn, MC
Letterman General Hospital
San Francisco, Calif.

Colonel John M. Welch, MC
McCormack General Hospital
Pasadena, Calif.

Colonel Charles L. Kirkpatrick, MC
U. S. Military Academy
West Point, N. Y.

GUEST CONFEREES

Colonel Richard Collins
General Staff Corps

Colonel Henry L. Thomas, MC
Procurement Branch, G-1
General Staff

Colonel Clifford V. Morgan, MC
Deputy Post Commander
Army Medical Center
Washington, D. C.

Lt. Colonel Schuessler, DC
School of Aviation Medicine
Randolph Air Force Base, Tex.

A. ADDRESS OF WELCOME. . . .Major General Raymond W. Bliss

Gentlemen, this is still the first month of the new year so I hope that it is not too late for me to extend to you personally my best wishes for 1948. I think that 1948 will be a crucial year for the Medical Department of the Army. I hope that it will be a successful year. But of this I am certain—the degree to which we shall solve our problems and the extent of our success will largely depend on our understanding of the difficulties that face us and our willingness to adopt a constructive attitude in solving them. We see each other too infrequently. One price that we pay for faulty communication is the uncertainty many of you must feel when you are asked to accept the results of our planning without really knowing why we are doing what we are doing.

I want to spend the next few minutes in outlining to you three major revolutions that are currently underway, which, before they have run their course, will have a great bearing on the Medical Department of the Army. These revolutions will change it, but in a way, I hope, that will leave us with a solid foundation so that we can continue to develop. There is a revolution going on within the Medical Department itself. Many principles and practices that were taken for granted in the years past have been suggested for reappraisal in light of our new situation. Those which have been unable to stand up to this searching reexamination are being altered. Despite faulty communication, I am sure that you are well aware that professional quality is the keynote of our new orientation. We want our doctors to grow professionally. We want them to practice medicine in the Army equal to the best in civilian life. There are only two standards in medicine, good and bad. The Army is interested only in good medicine. To that end we are currently engaged in the elaboration of our postgraduate training program to which so many of you have already contributed so much. I cannot forego telling you that Dr. Thomas of Johns Hopkins University, at the end of his recent tour of duty, reported to General Paul that what he saw of this program at Brooke—and he saw it all—was equal to the best with which he was acquainted in civil life. For a program scarcely more than a year old this was high praise indeed. We cannot all become orthopedic surgeons, dermatologists, or cardiologists; but each member of the Medical Corps can and will grow within his field of concentration. To this we are now moving from the exploratory to the operating stage in our career-finding program. As far as is humanly possible—and that is quite far—we hope to take all the necessary action that will contribute to a young man's professional development. And this time I use "professional" in the broad sense of the term. It includes the future clinician, administrator, or expert in preventive medicine.

Since you represent the administrative leaders of our Corps, I think it might be well for me to stress that in the future we hope to make it possible for a man to go to the very top of the Corps without being forced to shift out of his medico-military specialty. Moreover, we plan to devote much greater efforts in training of our medical administrators. One more word on this point. We are about to reappraise the relations of our hospital commanders to our professional chiefs. The details must still be worked out.

Our second revolution bears on the change in relation of the Medical Department to the Army. It is no secret to you that for many years the operations of the Medical Department have been seriously hampered by the cumbersomeness of the military structure within which we operate. All I can tell you is that the present high command is very sympathetic to any and all plans which we shall submit to alter these old arrangements in order to heighten the efficiency of medical operations. We need to have greater technical control over our medical means. We are short of men today. As time goes on, we shall be much shorter. We must devise plans to use every doctor to the fullest extent on professional work and have enough of that to keep him busy. If we do that, and I'm sure that we can, we shall not only reduce our requirements by a substantial amount, but we shall add to the morale of the Corps by providing opportunities for a man to be professionally busy all day. If we do that, we shall also be making a contribution to procurement; for many doctors, the kind we want most, will not come into the Regular Army unless they are sure that they can live a full professional life. I cannot tell you in detail how we plan to accomplish this particular objective of redesigning the pattern of medical care. But I can give you one indication of the lines along which we are thinking. During the war, we made one effort at area hospitalization. We called it the regional hospital plan. But it was a rather static approach. We simply designated various facilities for various purposes, and instructed the hospitals in the areas to transfer patients accordingly. Of course, we reflected differences in missions in our staffing. This was the beginning, but I think we can and must do much more. I believe that every doctor in the Army must have a hospital as his base. He must belong. If he is assigned to an outlying dispensary, it does not follow that he must remain there all day. Perhaps, two hours in the morning with a nurse on duty all day will be ample. There is no reason why he should not return to his hospital base after his dispensary hours have been completed and work in the hospital for the rest of the day. Similarly, if there is a station hospital like Belvoir, some 15 or 20 miles distance from a general hospital like Walter Reed, there is no reason why the young doctor assisting in ophthalmology who sends his more difficult cases to the general hospital, should not be able to spend two or three half days a week on the opthalmological service of the general hospital, following up his old patients and benefiting from the clinical experience which would be his as a

member of a service in a general hospital. Of course, such a system will necessitate an area medical officer who will have control over all medical means in the area.

The Navy has just developed an organizational arrangement in which The Surgeon General has in each area a personal representative who, in addition to controlling all medical means on behalf of the Bureau of Medicine and Surgery in Washington, also serves on the local commander's staff. We in the Army hope to profit from this. I may add that, in the deliberations of the Forrestal Committee on Unification, each service is trying to profit by adopting the best that the other service has evolved. That is one sure road to successful coordination. Of course, we are pursuing many others.

The third revolution currently underway relates to the changes which have already come about and those that will still come about between the Medical Department in the Army and the civil medical profession. The day of isolation is over. We are not self-sufficient, we cannot be self-sufficient even if we wanted to be, and we should not want to be self-sufficient. The Army belongs to the people. Army medicine is a branch of American medicine. We have been the fortunate recipients of the most valuable assistance from the civil medical profession, especially from those leaders who served with us during the last war. It is only necessary to call attention to the Medical Advisory Committee to the Secretary of the Army, the Medical Consultants Society of World War II, and the many individuals who served as consultants to my office and to your offices; but most important, to the many who are acting as attending physicians at our larger hospitals and who are carrying so large a part of our crucial postgraduate training program. We have every reason to be proud of the Army Medical Department and what it has accomplished in the past and what we all hope it will be able to accomplish in the future. We all have reasons to be concerned about the continuing welfare of the Medical Department. It is my considered opinion that by integrating civilians in our work and by the civilians integrating us in their work we can strengthen the Medical Department of the Army and American medicine of which it is a part and together grow stronger and stronger. I may tell you that medical schools have already begun to add some of our men to their faculties.

By reforming ourselves, by reforming our relations with the Army, and by reforming our relations with civil medicine we are laying a solid foundation. No matter how trying the situations that we shall be forced to face during the coming months, when the impending personnel shortages will be a problem, no matter what our other trials may be, we must not weaken this foundation. For if the base is strong the structure to be erected on the base will endure. I am sure that everyone of us is committed to making the Medical Department of the Army as strong as possible so that it can continue to serve with distinction.

B. STATEMENT OF CONFERENCE AIMS....Brig. General George E. Armstrong

Gentlemen, I am very happy to see all of you. I apologize if I more or less stick to a little prepared script this morning, something which I do not ordinarily like to do, but I am doing it primarily because of the time element. The aims of this conference are manifold. The chief aim, of course, is to bring together your thinking and ours in such a way that our approach to the current problems of the Medical Department is more or less standardized. The policies of The Surgeon General and the Medical Department today are at wide variance with those of a few years ago. I think I am safe in assuming that the bulk of our personnel are familiar with these new policies. Our problem, yours and mine, is to see that those policies are known and carried out by every person in the entire Medical Department. The success of any organization depends not on the formulation of policies at the top, but in their complete and thorough dissemination and then finally their ultimate utilization. Conferences, such as this one, as The Surgeon General has said, should be held more frequently. But frequent conferences are not expedient. Hence, we shall try to compress into two short days the material we should take weeks to discuss, and undoubtedly many important subjects will not even be touched on. Even so, it is expected that the agenda are such that some time will be given wherein you may visit the divisions of the office in connection with those problems that are peculiar to your bailiwick and not of general interest. By the way, our key people in the office will be here on Saturday morning.

As you will note from the agenda, a great deal of emphasis is placed on what we consider our two most pressing problems; viz, the consultant program and personnel procurement. The former is important because of the dependence which of necessity--and choice, I might add--we are placing today on our civilian assistants both for the care and treatment of patients and for our training program. Our consultants must for many reasons be employed most carefully. In the first place they must be employed economically, as you will learn later in the conference; although we have a tremendous sum of money set aside for the consultant program it is not enough to warrant ill-considered use of the consultant services. Secondly, the importance of the consultant in our teaching program is such that he must be looked on as any other attending staff officer and must be trained to accept and to fill a very personal responsibility for his part in the hospital activities, whether the latter be at a station or general hospital. I will not take up more time on this subject, as we have several other speakers who will elaborate upon it.

The personnel procurement problem is an extremely grave one. If you could know the man-hours that are being put in, attempting to arrive at the solution of this problem in this office, you would be thoroughly amazed; and yet, with all the plans that may be formulated

here, the answer to the procurement problem is in your hands. No amount of printed material or press releases or personal letters will draw the personnel that we desire and so vitally need. Personnel can be obtained only by personal contacts. I am very firmly convinced of that. When an individual, for example a doctor, be he a recent graduate of a medical school or a professor of medicine at Hopkins, like my friend Doctor Thomas back there, comes to The Surgeon General's Office to make inquiries about an Army career, everything stops, and everyone from the most recently hired CAF-2 up to General Bliss gives this individual his undivided attention. He is personally hand-carried from office to office, with pep talks from consultants, officers of the Procurement Branch of the Personnel Division, and finally The Surgeon General or his Deputy, whichever one happens to be free at the moment. Yet too often this same doctor has been on duty day after day, week after week, perhaps for months or even for a few years in an Army hospital without any one ever having talked to him about a military career. We hold conferences in this office to which are invited representatives of your installations and organizations. Days are spent discussing procurement problems, directions given for programs and propaganda, and weeks later we find lieutenants in your organization who do not even know that an ASTP with six months' active duty can make application for the Regular Army. I remember at a conference of general hospital commanders a little more than a year ago, when several of you were here, I was asked to make some impromptu remarks regarding procurement of medical officers. I cited the example wherein the young officer reported to a general hospital and was treated in exactly the same manner that I was treated twenty years ago, an interview with the executive officer, opportunity given to express a preference of the type of service desired for assignment, and the young officer was then promptly informed that he was being assigned to an entirely different type of service, without any explanation as to whys and wherefors. Gentlemen, this does not procure personnel for the Medical Department today. Every officer, including those in the Medical Department, must be treated as you and I would like to have been treated twenty years ago. It is a new deal whether we like it or not, and the approach of men like General Willis on my left is the only hope by which I think we may ever expect to attain our goal. Every officer, regardless of the corps, and I dare say almost every enlisted man who reports to Brooke Army Medical Center, is very promptly and personally interviewed by the commanding general of that Center. The man or woman is allowed to discuss freely his or her thoughts regarding the military service. Every opportunity is given to express preference and every opportunity is taken by the commanding general to attempt to solve the medical problem; but that is not all. This same gentleman, and I trust you will pardon this personal reference, does not satisfy himself with the initial personal interview, but from time to time sees these same individuals, especially the younger ones, to discover if they are satisfied with their services and whether or not anything can be done to make their personal or professional life more pleasant and attractive. Gentlemen,

this is not a purely Medical Department problem. It is a part of the changed times, and personnel handling and personnel procurement must be personalized whether you are dealing with Medical Department personnel or the employees of General Motors.

Too often we hear stories, many perhaps unfounded and many unquestionably true, wherein the doors of the commanding officers are closed to all but the key members of the staff. Not long ago a young officer of the Regular Army Medical Corps on duty at one of our general hospitals initiated a letter of resignation. It left the hospital on its way to the Adjutant General without one single soul calling the officer in and discussing the resignation with the view to discovering and removing, if possible, the cause of his action. This means that the chief of his service was not sufficiently interested, it means that the executive officer was not sufficiently interested, nor adjutant, nor the commanding officer. The papers were forwarded over the signature of a warrant officer who treated the paper as he would a routine requisition for supplies. The holding of the people that we already have in the regular establishment is an even more important part of our procurement program than is the bringing in of completely new and untrained recruits.

We have discovered that perhaps our most important and valuable, if not our only important and valuable, instrument by which we may hope to attract young officers, particularly in the professional corps, is our professional training program. Rightly or wrongly, one-sided or not, this is a fact of which we are convinced in this office. This means that all of us must look to our training program not only in our teaching general hospitals, but also in every medical installation which we operate. A station hospital or dispensary may and should become a training installation. This means that the concept and importance of training must permeate down through every small tributary of our entire medical system.

A training program not only offers our best procurement inducement, but at the same time it stimulates and elevates the standards of medical service throughout the Army. A young major who attempts to use clinical material which he has in a dispensary for teaching purposes learns just as much or more than the young lieutenant whom he is endeavoring to teach. While I am on the subject of teaching and elevating the standards of medical service, there is another phase of medicine from which the profession is straying far afield. This is a problem which affects civil as well as military medicine. I am referring to the lack of appreciation by young doctors both in and out of the service of the importance of the art of the practice of medicine. I can remember as a boy that my grandfather told me that in his opinion the art of medicine was ninety-five per cent, the science five. With the increase in technical knowledge I am sure that the latter figure no longer obtains. It is far greater but there still should be a tremendous importance placed on the art. This problem has

been discussed with various medical educators, and they agree that the blame should be placed on our medical schools. Be that as it may, we have in the service today several thousand doctors who have not the slightest concept of the proper doctor-patient relationship.

As I go about the country I am constantly encountering examples of the failure of young doctors, and I might add that in some cases the older ones, to treat the patient as an individual and not just as another "case." And that is particularly true with the emphasis being placed on training. I was down at Ft. Monroe the other day and Colonel Blesse had just run into a couple of examples. A young doctor invited a young lady into the pre-natal clinic. He looked at her record and her weight that the nurse had just taken and found that instead of losing three pounds that she had been instructed to do the month before she had gained three. He threw the record on the desk and said "get out, you are not following our directions, we want no part of you." Now George Reyer brought up a case just yesterday. A call from a sergeant: his wife had just had an accident, and she was bleeding profusely about the face. It was 4:30 and the young man said "call back at five o'clock, the OD will be on then and he will come out." Those are examples that you are all encountering every day. It is a problem which is very difficult to correct. The long range correction depends on the examples set by the more mature medical officers. The short range corrective program should include frank discussion of the matter by commanding officers with their professional staffs. If the commanding officer feels that he has some one more able to discuss it, as, perhaps, the chief of one of his major services, by all means delegate the job. But some one should, from time to time, take time out to emphasize the importance of the doctor-patient relationship. General Bethea, in a bulletin not long ago, put out a very fine paper on this subject. It was written by Lt. Colonel Bauer. He emphasized the fact that patients should be seen every day by some one. We are not doing that. The chiefs should see them regularly too, as often as he can, perhaps once every four or five days or perhaps once a week. But patients should be seen. If you are not doing anything for the patient, tell the patient why nothing is being done for him. Don't belittle other installations and other doctors in front of the patient. See that your senior officer doesn't bawl out, as we say, the junior officer in front of the patients. The same, by the way, applies to your staff conferences, as I understand that the practice obtains in some places. There are many other phases of this matter. We have tried to think of a way to get it on paper and get it over to you, and decided in favor of bringing it up today. It is something that we strongly feel you should pass on--I am speaking particularly of the Army Surgeon--pass on to your post surgeons, and see that something concrete is done about it today, and then see that it is emphasized from time to time as is necessary.

There are various other ways by which the service can be made more attractive. I have already emphasized the importance of the personal

contact, particularly on the part of the commanders, and the importance of its follow-up. Secondly, the staff should be kept informed as to what is going on not only in its particular installation, but in the Medical Department as a whole. Now we realize that too often the latter information does not receive sufficient dissemination in this office. This we hope to correct. But when we get the information to you gentlemen we expect that it will promptly go on down not just within your own office, but to every individual assigned to your installation or to any installation within the scope of your responsibility.

A constant and a thorough check should be maintained by all operators to assure that no administrative task is being done by professional individuals that properly could be done by administrative personnel. Incidentally, the other day we had word, George (Rice), that one of your posts had been cut greatly in its Medical Service Corps personnel just as they had plans to take over a lot of duties which have been done by professional men. We discovered that the Medical Service Corps was the only corps in your area on which we were not controlling your allotment from here, so that will not be an excuse in the future. Your cut wasn't sent from here. No blame to anybody, and we'll try to get it rectified for you.

Next is the matter of rotating personnel in the performance of more mundane tasks. We recently had a letter from Bob Hill. He gave the most beautiful picture, and a very drab one, of the personnel procurement situation at Ft. Benning today. No fault of the Army Surgeon, no fault of Bob Hill's. I won't say where the fault is. At any rate, they are insisting that his officers do a lot of duties which to all intents and purposes could be done by well-trained enlisted men. You know, those of you that have served at Benning and the other service schools, they want doctors out on every little problem, etc. I am not speaking of the times you send out troops to take part in a tactical exercise. Now the approach to that, if you can't sell the commander on the economy of force by sending an enlisted man that's well-trained to do the job, is to explain to your junior officers why it's having to be done, and then rotate the thing and not make the same individual do it day after day, and week after week. Another thing is the matter of your men in the dispensaries. As mentioned by General Bliss a moment ago, we're trying to build up the concept of a medical center at each post, and, if it is possible, to operate your dispensaries by men assigned to the hospital so that it's a part-time job. That's the idea. If you can't then by all means rotate them. I agree with your thinking that a man learns more medicine in a dispensary than in any other place. It was my experience, and I am sure that it was yours. But that's not the way these lads feel about it today. The dispensary still must be operated. Therefore, we must do it in such a way that will keep these lads the happiest that we can make them under the situation with which we are now dealing.

I rather doubt that we shall have time during this conference for any prolonged discussion of our reserve problems. They are most vital,

and should receive the utmost consideration by all of you and by your assistants. The importance of stimulating medical personnel of all categories in our reserve program is one of our biggest challenges today. Various officers in The Surgeon General's Office have been working for months on concrete plans that may give us something that will interest the busy and the worthwhile civilian personnel whom we should like to reach. Your officers are working, too. For the first time, Reserve and National Guard officers are in attendance this week at our course on medical aspects of nuclear energy. This is one of the fields of great interest to civilian doctors particularly--one which we should exploit to the highest degree.

Those of us in the office are thoroughly sold on the soundness of our current program. If you are not sold I believe it is because you are not sufficiently familiar with it. That, then, is the chief aim of this conference. To let you know how we are thinking and what we are thinking, with the idea that when this is accomplished you will go back imbued with the spirit of passing on to others what we are trying to pass on to you.

C. THE CIVILIAN CONSULTANT PROGRAM.....Colonel Frank L. Cole

General Bliss and gentlemen of the conference; I have a few things to distribute to you before we start the actual discussion. Here is a list of all consultants that have been appointed in the office. I should like all of you to have it. And these two lists have been compiled by the Education and Training Division from information which they have obtained from hospitals, on which I will speak a little later in this talk. But I should like these distributed now.

The subject which has been assigned to me as you have seen on the agenda is "The civilian consultant program." The civilian consultant program, as you may or may not know, was planned, at least the plans were started, in the latter part of 1945. In the beginning of 1946, these plans became more concrete, so that we were at that time beginning to appoint a certain number of civilian consultants. This program was originally instituted because of the success which had followed the use of expert professional consultants during the second World War. As you all know, following the war we lost a great number, in fact all of our high-powered civilian consultants, I mean of our civilians who were in the Army and were acting as Army consultants, and as the result of that it was necessary for us to build up a civilian consultant program out of those men who had had service and out of other men who had been recommended to us by the Civilian Consultants Society. Following this meager start in 1945 and going on into the early part of 1946, in May and June, we began to appoint these consultants. There was considerable confusion, naturally, as to what their duties were and how they would be integrated into our Army hospitals. Also about that time there was being promulgated the residency training program.

Now this residency training program and the civilian consultant program are two programs that we feel must work hand in hand in order to attract young officers who may want to make the Army Medical Corps their career. Following this, we began to get a number of applications for appointments as consultants. And this program was gradually built up until the beginning of 1947, when the actual residency training program went into effect. By that time we had set up in all our hospitals, all our training hospitals, a good many of our station hospitals, and in all our army areas, a pretty good nucleus of civilian consultants. Now these consultants are to assist in the treatment and care of patients and will have several functions; one of them of course is to assist in the care and treatment of patients. They are the bulwark, so to speak, of our consultant program; so that whenever problems come up with respect to patients we can call in these consultants, or the consultants can treat the patients when they are making their regular rounds through the hospital, so that all our patients should be covered with a very fine line of expert medical attendance. Now the next and another important duty of these expert consultants is to assist in the residency training program. As you know, when the residency training program was set up, it was done with the idea of getting as many men

through the specialty boards as possible, so that we could carry on our program under our own power rather than rely too much on our civilian consultants. We have felt all along that this civilian consultant program may not hold out too long, because it depends entirely on appropriations from the Congress. However, up to the present time, our appropriations have been ample and we are still able to carry out this program, and, as far as we know, we'll be able to carry it on for a considerable time. In the residency training program, our consultants are to act as teachers and adviser operators, if necessary, make ward rounds, teaching rounds, in order to instruct and carry on the program that is outlined for the training of our men in residency and also for the interns and others who may be taking refresher courses. Now the present outline of policy is covered in a general way in Change 5 of AR 40-10, which came out 21 October 1947. That's a revamping of the original Section III of WD Circular 101, which came out in 1946. We have consultants set up in every specialty that is peculiar to our hospitals. We have surgical, medical, and all the various subspecialties throughout the medical set-up in our specialized hospitals. All hospitals do not have all the subspecialties set up, for the reason that they do not specialize or do not have patients in every class which may be represented in these subspecialties in medicine. We have three classes of consultants. Headquarters or SGO consultants are the ones who work in conjunction with the offices here in The Surgeon General's Office. We have army area consultants. They are appointed for the surgeon of the army area and through him are used throughout the area in the station hospitals. In some station hospitals, for instance at Bragg, at Knox, and at Benning (large station hospitals), we have consultants who are appointed locally for those particular hospitals. However, these consultants are all appointed to the army surgeon of the particular area, although they may be set aside for particular use of that station hospital near which they reside. However, they are under the direction of orders of the army surgeon and to be used any place in the army area where that army surgeon wishes to send them or the consultant wishes to go. In some instances we have run into difficulty in the army areas sending, or having moved by the army area surgeon, a consultant from one city to a distant place because the consultant feels that it's too far away and he can't spare the time. But fortunately those cases have been very much in the minority. Most of these consultants have responded most graciously to every call which has been made on them.

Then we have the so-called teaching consultants or consultants assigned to our general hospitals. Originally when the residency training program was set up, as you know, we set it up in practically all of our general hospitals. After a year, we found this program could not be carried on successfully in all of our hospitals because of local conditions which prevail, over which we have no control. So, beginning the first of this year, that is the first of January 1948, this residency program was curtailed to five general hospitals that we now designate as our teaching hospitals. Now the consultants who are

assigned to these teaching hospitals have multiple duties to perform. In the first place, they are the teaching consultants. They are the ones on whom we are relying to teach and train and guide our residents who are training. They are the ones on whom we are relying to get credit for these men for their board certification. I think most of you realize and know that, before a man is eligible to take the board examination, it is necessary for him to be trained in a recognized hospital that is accredited by the particular specialty board. So it is necessary that the hospital be sponsored and have on its staff regularly assigned board members of the particular specialty our man is to be certified in. I am going over this rather hurriedly because our time is somewhat cramped.

There has been some confusion as to how these consultants are to be appointed. So I would like to take just a moment to clear up this point. The consultant is recommended by the army surgeon, if it's for an army area, writing to this office and stating that he has a gentleman by the name of John Jones, or whatever it may be, whom he wishes to have appointed as a consultant to his army area. In this letter, the army surgeon should give the man's background, his name, address, training, education, and so on, and the particular board in which he is certified. When these names come in here, they are cross-checked, and we try to obtain from our contemporaries on the civilian consultants committee, the committee which is made up of consultants of World War II, an opinion as to this man's ability and what they think of him. Many times this is not entirely necessary because these men are outstanding and do not belong to the organization to which I have referred. However, these names are gone into very carefully, and the backgrounds are carefully checked, and then from this office an invitational letter is written to the man, his Form 57 is sent, and he is asked to fill in that form and return it to this office. And in the letter it is stated that he has been recommended by the army surgeon in a particular area for assignment as a consultant on his staff. Now the same thing holds true of the general hospitals. These names should be submitted by the commanding officers of general hospitals through this office, giving the background of the individual, and from this office the papers will be sent to the man, and he will be invited to become a consultant. If that is not done, and in some cases it hasn't been done, the papers have been sent directly from the hospital to the man, and the next thing we knew here came the application with the man's papers. We may, in checking over our files and checking back with this consultant's society, find out that that man is not particularly the man that should be appointed for that particular position. In other words, he is not recommended as a consultant. Then there is an embarrassing situation, because the man has already been invited to come in; he has filled out his papers and sent them in, and we have to write him a letter or write back to the commanding officer and ask him to write a letter and tell the consultant that unfortunately circumstances do not permit, at this time, of his being appointed a consultant.

Now as to assignment of the consultants: Consultants appointed to army areas are assigned and under the direct use and direct supervision of the surgeon of that area. He usually uses them as he sees fit, sending them on trips to go around and visit his station hospitals, and he may send them very often. He may send them to investigate particular problems; he may have something happening in one particular hospital that he wants investigated by an outsider; he has his consultant when he can send in there and make a report for him. The consultants assigned to the general hospitals are assigned by this office. We write a letter, when the man has been appointed, and say that this man has been appointed and that he is now ready for use by your hospital or army area.

The salary of these consultants as you know is $50.00 per day, plus six dollars per diem for travel. There has been some question recently on this six dollars per diem. I think it was brought up by Colonel Gorby yesterday, and we have the answer for you Colonel Gorby, which we will give to you later. Now there are a few deductions that are made on this $50.00 a day, so that, when a consultant asks you how much money he is going to get, you can tell him that he is going to get $50.00 a day, less certain deductions which are mandatory by law. These deductions that are mandatory by law are: that a man can only work so many hours a week, and that he can't work a full seven days a week as most doctors do, but under Civil Service Regulations he can only work five days a week. We run into this when we use our overseas consultants. So, for the time being, most of these consultants are not used for a length of time longer than five days, unless they are on some special mission or some overseas mission or something of that kind. But our consultants in this country who are assigned to the army areas and who are assigned to general hospitals rarely work over five days a week.

Now it has been General Bliss' recommendation for a long time, and we have tried to get this into operation and I think in some instances it is in operation, for the appointment of one consultant in each major specialty to act as the coordinator for that group. I am sure this can be worked out very satisfactorily in the general hospitals. I think in the general hospitals it will be no trouble at all to have your education committee designate one officer who will act as the coordinator or the chief consultant or whatever you want to call him for the group—for instance, the surgical group or the neuropsychiatric group or the medical group. In army areas this is going to be a little difficult, especially in areas that are large and areas in which the population is centered in certain centers. For instance, we'll take the Sixth Army Area, and I have talked this over with Colonel Gorby. He has three centers of population: one in the south, one in the bay area, and one in the north. I think it would be impractical for him to appoint one man for his whole area who would be the coordinator of consultants for the whole specialty which he represented. I think perhaps he should appoint one in each one of

these groups—one of these areas perhaps, if he could, but I think it would be an impractical thing for him to appoint a man in medicine, say in San Francisco, who would coordinate the medical activities of the ones up in Seattle. That may be true in other army areas. However, in the closely knitted army areas like the First, I think it could be worked out very well so that one of these coordinators could be set up for each specialist group. If this man is appointed, and in many instances he already is appointed, and we are hoping that he will be appointed in all general hospitals upon your return, this should be carefully considered by your education committee at each hospital. Let your consultants pick out the man, with the advice of the commanding officer, of course. It may be, and I think it probably would be, an excellent idea to rotate these people and not put one man in and leave him there forever; because we realize, and I am sure you gentlemen know, that there are petty jealousies among these consultants. If the consultant is appointed as the chief consultant or chief coordinator or whatever you want to call him, it may set up a little friction and little jealousy among the other consultants unless this is done by the consultants themselves or unless they are well represented on the committee which does have the final appointment of this man. If that is done, then I think you will have no trouble, and they will have no reason to flare back at the commanding officer because he picked out a certain man to act as the coordinator of consultants.

The question is brought up from time to time as to how the money is holding out on these consultants, and I have some charts that have been prepared by Colonel Duke's division after he obtained a great deal of information from the hospitals. And here is an analysis of the obligation for consultants for the fiscal year 1947, that is, up until the end of last June. As you will notice beginning in January—that's when we started this consultants program really with a bang—the amount of money spent went up very fast. These represent tens of thousands of dollars, and finally, when we get it all totaled up, we have spent at the end of the fiscal year $229,345 on the pay and travel of consultants. Now in the general hospitals this represents 478 consultants; the station and regional hospitals, remember, are not represented here. The Army Medical Center, the Army Institute of Pathology, etc., $22,015.20. For department consultants, that means for consultants here in The Surgeon General's Office and the activities connected therewith $43,000 and then on down the line. Notice that the amount spent for consultants in the fiscal year ending last June 30 was $424,812, and we had appropriated $92 4,000. So you see we fell far behind spending all the money that was actually appropriated for the number of consultants during that year. This year, so far, we have $9000,000 appropriated for the use of consultants, and for the first five months of this fiscal year up until the end of November we have spent $299,000 or approximately one-third of the total amount which has been appropriated for this fiscal year. In addition to this, however, we are establishing now, beginning this month, overseas consultants. We are trying to send, and I am setting up now, these teams to go over, and we expect to send at least three consultants each month

to the European Command and as many as we can get to send to the Pacific. We won't have three each month for the Pacific but we will have three in perhaps alternate months if we can get that number to go. And that's going to make a great cut into this amount of money which has been appropriated; but so far we are well within our appropriation. If we, in five months, have spent $299,000, practically a third of our money, we are still well within the amount which was appropriated for the whole year. But with this overseas consultants deal which is going on now, it's going to boost up the amount of money spent for consultants many times over what it is now.

The time is running out, but there are two things which I am very eager to present to you, and these are the two sheets that were distributed to you in the beginning of this talk. On one we take the consultant activities for the four teaching Army general hospitals. For four teaching Army general hospitals (it was only from four teaching general hospitals that the information necessary to compile this was obtained) this is the breakdown to show you how these consultants are used and the amount of time and so on that was devoted by each one of these consultant groups to the particular specialty involved. In medicine we have fifty-one consultants, and the number of visits from the first of July, i.e., for the first six months of this fiscal year, were 1,313. I am just going over part of this, but I want to go over that much to familiarize you with it, and then you can study it at your leisure. In medicine, the average duration was two and a half hours; in surgery, four and a half hours; anesthesia was ten hours; neuropsychiatry, five hours; radiology, only two hours; and pathology, two hours. Now what we are endeavoring to put over to you gentlemen at this conference, so that you can take it back with you after you have studied this, is the amount of time which your consultants are putting in. You will find that in a large number of instances, your consultants are not putting in enough time in the hospital. Now I have gone to hospitals, and I believe that this isn't peculiar to any particular hospital. I think it is peculiar to most of our hospitals. There is a great deal of time spent by consultants in going over the niceties of the day. Sitting there talking about the party they went to and so on, and then finally they come around and say, "Well, what are we going to see today," and the chief of the service or the section says, "Well, I have a couple cases up here I would like you to see." So he goes up and sees these two cases, and that is the end of the visit. Now that is not what we consider an ideal use of consultants. These consultants are men of high repute in their neighborhood, high repute in their district and cities, men who are leaders in medicine, and we want these men to be used for the purpose for which they were appointed. I feel that in many cases they are not used to the fullest extent. In this chart you will notice that in many of these instances these men are not used to the full extent. Then if you go into the next column of the general activities of consultants you will find the number of ward rounds; in medicine, 885; surgery, 1,201; anesthesia, 110. Anesthesia I think can be excused from ward rounds because their work will not be on wards. Their work will be in an operating room.

Neuropsychiatric, 291. Radiology and pathology of course would not require ward rounds. The number of lectures in medicine was 186; the number in surgery, 366, and so on all the way down. Now what we should like for you to do is make a shift in this from the number of didactic lectures, for instance, except those that are required, to increase the number of teaching ward rounds. We feel that most of these men in training get their greatest help and their greatest amount of knowledge from teaching ward rounds. Now we don't mean by that that all talks and didactic lectures should be abolished. Far from it. But we do feel that there should be a definite shift from the didactic lecture in favor of the teaching ward rounds. Now as to the number of conferences--these conferences are very valuable. These conferences can be very formal or they can be very informal. But I think an informal conference in which the residents and staff are brought together and cases are discussed informally with the consultants and with the staff is an excellent way of teaching. The number of operations of course, will be a variable one and will depend on the ability of your chiefs of surgical service, on the ability of the men on his staff and his sections, and also on the number and type of severe operations and so on which are performed in that particular hospital. So that is a variable and need not be paid much attention. However, there was a question brought up in our questionnaire that was sent out. It asked: "Can consultants perform operations in hospitals?" Of course they can. Consultants can perform operations in hospitals. That's one of the ways of teaching, and that's one way of treating patients. There shoul be no hesitancy, whenever the chief of the surgical service or any of the sections of surgery is in doubt as to his ability to perform any operation, in calling on the consultant and asking him for help. Now the estimated value of these consultants and so on in the last column, the one on the right: you see the estimated value is excellent, good, and poor. And you will find them as listed in this column.

On the other sheet, are consultant activities again. These are the cost of consultant activities, which have been figured out by our fiscal division that made a breakdown of this chart. You can see from this exactly what your consultants are costing you. You can see from this the average duration of the visits, as we had on the other chart, the number of ward rounds, number of lectures, number of conferences, number of operations, and other activities. Then you have an estimated value of the consultants over here on the next to the right hand column, which is an evaluation that was sent in by you gentlemen from your hospitals. Now you will see that some of these are marked excellent, some are good, some on whom we had no record, and some are marked poor. As to these consultants who are marked poor and on whom you render a report that they are poor: when it comes to reappointing these men next June you will all be sent a letter to recommend consultants whom you wish to reappoint for the next fiscal year. That's the time to drop these people. Just drop a letter to this office and state that the following men as consultants are recommended for reappointment and the others are not recommended, and then we can drop them and not reappoint them. This is a hurried summary of this because our time is running over and the discussion will come up on these points later.

DISCUSSION

GENERAL BLISS: I would like to say something at this point with reference to Colonel Cole's discussion. We had a bill in the last Congress that would permit us to employ civilian consultants the same way that the Veterans' Administration does on a full or part time basis. We are going to ask for that legislation again. I think it will solve some of our administrative difficulties if we're able to put men on salaries rather than on $50.00 a day, and it will probably be a little cheaper. I think in the main that the consultants that we have are actually an attending staff. I think they should not be considered primarily as consultants but rather, particularly in the hospital, as attending surgeons and attending physicians. Roughly speaking, during the war we had a full time, competent staff in each hospital, without any attending men. Civilian hospitals very generally throughout the country have no full time men except their interns and residents.

It is somewhere in between that we must get, so that our men coming to our general hospitals will, in fact, correspond to the attending physicians and attending surgeons as they operate in civil hospitals. I think our consulting service can be exemplified, perhaps in an example, again in obstetrics, that we had in one of our hospitals recently. It was an obstetrical service which was rather extensive in numbers of deliveries a month, and that hospital obstetrical service was and is in charge of a man who had had only a rotating internship and who desired to do obstetrics. He is doing that. He has, or had, no particular supervision. He is a good man, there isn't any question about that at all, and he is doing good work. However, to place a young man like that in charge of a fairly large obstetrical service, or any other kind of service without supervision, is not good medicine, according to present day standards. Now our conception is that, in instances like that at our hospitals, the service should be in charge of, or supervised by, a competent man, whether it be one of our men or whether it be a civilian consultant. This does not mean by any means that the civilian consultant should come every day to the hospital, but he should be so much in charge of that service that he can satisfy himself that the service is being carried on properly, and the staff is performing according to the best standards, and he will be available when necessary, too, for any emergency calls. One other program which I wish briefly to discuss is our plan to send consultants to the overseas theaters. As far as Europe is concerned, we are now planning to send three consultants a month as a team. One of these men, incidentally, will be either an Army, or a Navy medical officer, qualified--that especially.

These teams will go to about fifteen hospitals in Europe. They will spend two or three days in residence at each hospital and will act in two or three ways. They will certainly stimulate the young men who are on duty in those hospitals. The young men will be expecting them and will have their interesting patients lined up. In a way they will constantly be supervised, for they will know that once a month they will be visited by three leaders in American medicine. Furthermore, we are arranging, and I think it probably has been pretty well consummated now, with the various specialty groups and the American Medical Association, that a certain amount of credit will be given to our young men because of the visits of these consultants. You know, they are all interested in having their work recognized. I just wanted to interpose that between Colonel Cole's and General Donit's discussion.

D. THE CONSULTANT PROGRAM,
FIRST ARMY.....Brigadier General Guy B. Denit

Our friends in The Surgeon General's Office have been good enough to say that the civilian consultant program is working exceptionally well in the First Army. Now, if that be true, there must be some reasons for it, and since my predecessor, General Walson, had initiated this program, I thought it was up to me, before talking to you, to analyze the reasons and give them to you for what they are worth.

Now, somebody has already said, for any program or any cause to be successful, there must be a firm belief by the leader in that cause as to the rightness and the justice of that cause, and I am a firm believer in this consultant program for many reasons. First, I am sure that, as General Bliss has said over and over again and all the rest of us have said, we all want the Army medical service to be the best service in the country; and we certainly cannot have this service under present conditions without outside help, because we do not have sufficient key specialists to meet the requirements, either in number or in quality. Therefore, we do need the help and advice of our friends, our civilian consultants. Since, then, they have been good enough to volunteer for this, we should make every effort to use them most effectively and most economically. Now, the consultants for the First Army Area are obtained in various ways. We all know, and General Bliss has referred to it, of the existence of this Consultant Society. This splendid organization has dedicated itself to assisting us in our professional problems. Therefore, I feel that we should use this friendship to the maximum extent possible. Then, before we select anybody or nominate anybody to The Surgeon General for consultant for the First Army, we are very careful. We not only make a thoroughgoing search of their qualifications, but we ask the opinion of one or more of the key members of this Consultant Society. I am thoroughly convinced that the fraternity of consultants should be a very select one and that the original members should be extended the courtesy of deciding upon its new members. I know of no better way in which to bring the whole program into disrepute than to initiate into this fine fraternity mediocre members.

When The Surgeon General writes the letter to the consultant nominated by the First Army to ask him if he will accept appointment, he tells him that the First Army Surgeon will communicate with him concerning his duties. Our letter to the newly appointed consultants is somewhat as follows:

"Dear Doctor: I have received a copy of your correspondence with The Surgeon General's Office and note with interest your questions

regarding the different aspects of civilian consultant's visits.

"In your letter dated----------to Colonel Blitch you asked several questions. I want to assure you that here in the First Army Area the duties of expert civilian consultants are entirely professional. It is certainly our intention that you be inconvenienced as little as possible with so-called red tape, so that your efforts may be expended solely toward the improvement of the Army medical service, and not concern you with other medical activities more military in nature.

"I am enclosing a copy of a letter dated 9 January 1948, subject: "Visits of Civilian and Military Consultants," in which was briefly outlined some of our views pertaining to visits of civilian consultants.

"The major medical installations under the jurisdiction of this headquarters are as follows:

Station Hospital, Fort Jay, Governors Island, N.Y.
Station Hospital, Camp Kilmer, N.J.
Station Hospital, Fort Monmouth, N.J.
Station Hospital, Fort Hamilton, Brooklyn, N.Y.
Staten Island Area Station Hospital, Staten Island, N.Y.
U. S. Army General Dispensary, 39 Whitehall St., N.Y., N.Y.
U. S. Army General Dispensary, Boston, Mass.

"While the installations listed below are under control of The Surgeon General, they sometimes call on this headquarters for services of Army civilian consultants:

Tilton General Hospital, Fort Dix, N.J.
Murphy General Hospital, Waltham, Mass.
Fort Totten General Hospital, Fort Totten, N.Y.

"In reference to your questions regarding the frequency of inspection visits, I wish to inform you that no definite schedule of visits is established. When we feel that a visit by one of the Army consultants to an installation is indicated, we make such request of the consultant. If the date is convenient to him, we arrange the necessary details, such as issuance of orders, arrangements for transportation, etc. Our present Army consultants make on the average of about two visits a month. These visits usually require only one day each, but they may, on occasions, require somewhat more time. Some of the hospitals close to or in New York, such as the Station Hospital at Fort Jay, Governors Island, may require a visit of only one-half day.

"I wish to take this opportunity to express to you my appreciation of your interest in the civilian consultant program of the

Army, and look forward to your serving with us in the capacity of consultant in----------.

"With kindest personal regards, Sincerely yours,".

Our consultants are employed in several ways. First we have Army-wide civilian consultants who, after working out with us a mutually satisfactory schedule, visit our various hospitals. In preparing the schedules we attempt to have an internist, a surgeon, and a neuropsychiatrist consultant visit each hospital in the First Army Area at least once a month. The consultants of the various other specialties are called on from time to time to visit the hospitals, but not in such frequency. Our schedules are arranged so that the other specialists visit each hospital from six to eight times a year. All of our consultants are encouraged to render rather full reports of personnel problems, diagnostic procedures, treatment methods, adequacy of equipment, etc. These reports first go to the commanding officer of the installation visited for his remarks, and are then forwarded by him to the army surgeon. We in the surgeon's office take these reports seriously and make every effort to follow with such means as are available to us the recommendations contained therein. The reports are then forwarded to The Surgeon General's Office, requesting help when such is needed.

Next, we have teaching consultants at Fort Jay, consisting of one surgeon, one internist, and one neuropsychistrist. The teaching medical and surgical consultants visit the hospital at least twice a week, but no reports are required, since we wish them to devote all their time to purely professional matters and to instruction. The teaching consultants will on occasion operate or assist in difficult cases.

The relationship between the commanding officer, the chiefs of services, ward officers, and the consultants has indeed been most cordial. All concerned welcome the visits of these consultants, and every member of the professional staff is benefited by the ward rounds and the round-table discussions. We want these teaching consultants in all of our station hospitals, since we believe this teaching program to be extremely valuable; but it has not been put into effect in other station hospitals because the professional staffs at these have not, in the past, been sufficiently trained to warrant such a program.

Another method of using the consultants is for "emergency consultations." The following examples illustrate this: An MP in New York City was shot through the head and rushed by civilian authorities to Roosevelt Hospital in a dying condition. When we were notified, we at once called Dr. Lawrence Poole, our neurosurgical consultant, and informed him of the situation. He visited the patient at once and

advised us that he was too ill to be moved. We requested that he perform such operative procedures in the civilian hospital as might be necessary. This was done and we are convinced that the life of the soldier was saved by Dr. Poole's quick and expert attention.

On another occasion, when Fort Totten General Hospital was first opened, we had our pediatric consultant visit the hospital to advise us concerning what was said to be a slight outbreak of infantile diarrhea. Dr. Joyner went to Totten immediately and advised us by 'phone that the hospital was not at that time sufficiently equipped to care for this outbreak. Upon his advice all babies were transferred to the Fort Hamilton Hospital where we had in operation a superior pediatric service. The mothers remained at Totten. After consultation with the commanding officer of Fort Totten Medical Center, it was determined that the obstetrical section of the Fort Totten Hospital should be completely revamped, and the obstetrical service there should be closed for the time being, and all obstetrical cases should be sent to Staten Island Area Station Hospital. We called upon Dr. Ralph W. Gause, our obstetrical consultant, to assist us with plans for a satisfactory obstetrical service. Thus, these obstetrical and pediatric consultants were employed extensively in drawing up plans and specifications for the modernization of the obstetrical and pediatric sections of the Fort Totten Hospital.

These consultants not only gave of their time and advice to this particular project, but assisted us in the re-establishment of the obstetrical section at Staten Island Area Station Hospital and in advising us to the care and treatment of the babies which we removed to Fort Hamilton. All the babies responded quickly to expert care.

In order to modernize the obstetrical service at Totten the sum of $50,000 was necessary. This money was not immediately available, but, owing to our insistence on the necessity for this work, and with the complete backing of the two consultants, the condition was considered by the First Army Engineer as of an emergency nature, and the necessary funds were provided. I am told that when the project is completed Fort Totten will have a model obstetrical set-up.

It was through the efforts of these same consultants that the high standards that now obtain at our embarkation and debarkation hospitals are being maintained.

Another example of the cooperation and use of the consultants was that just recently we asked Dr. G. G. Duncan, one of our internists in Philadelphia, to investigate what was believed to be a high incidence of atypical pneumonia at Fort Monmouth. This contact was made by telephone and in a few days a thorough investigation had been made, and concrete recommendations were submitted. I would like to point out in this connection that Dr. Duncan found that it was owing to the expert diagnostic procedure being used by the young medical officers of that

hospital that these atypical cases of pneumonia were discovered, and that the incidence rate probably was not excessively high, but that all such cases were promptly discovered and reported.

We believe that we have in our army areas Regular Army medical officers of such high calibre that they too are capable of acting as consultants. Therefore, with the approval of the commanding officer of one or two of our station hospitals, we have appointed members of their staffs as consultants to the First Army. These excellent young officers have frequently been sent to our smaller station hospitals not only to act as consultants to officers with less experience, but to perform operative and diagnostic procedures as well.

Our commanding officer of the First Army Laboratory is likewise employed as a laboratory consultant for all of our Army installations, makes frequent trips. The same can be said for our physiotherapist and dietitian. We also use the best of our mess officers to assist in establishing ideal conditions in other messes.

The question has been raised, and I am of the opinion that it is The Surgeon General's policy, that a chief consultant as coordinator should be appointed in each army area. I believe this policy to be unwise for many reasons. First, most of our consultants do not have the time to act in a supervisory capacity in addition to their professional visits to our installations, nor do we want them to expend their time on this work. Second, it will take a Solomon to make a choice when so much talent is available. Third, consultants are individualists and want to consult with the chief surgeon rather than with an intermediary. Fourth, we believe that every use should be made of the consultants, and that the program should be run as economically as possible. I believe the army surgeon is in the best position to make the best use of the talent made available to him in the most economical manner. I know from personal experience that consultants do not like to have a boss other than the chief surgeon. We feel that in this day of modern medicine we should not rely solely on the viewpoint of one doctor or on the medical opinion of one section of the country. It is a great source of satisfaction to us to know that we not only can have consultants from the New York doctors but also can call on those from Boston concerning the same condition and can thus evaluate better the recommendations made.

The question has been asked me whether or not we are appointing too many consultants in the First Army Area. My answer to this question was "No," that in the First Army we have only one consultant in pediatrics, roentgenology, thoracic surgery, neurosurgery, and obstetrics and gynecology. There should be several consultants in each one of the specialties, because, by having a larger group available, it is possible for us to secure at least one who may have the time to accomplish a particular visit for us. We also want to get at least one representative for the following specialties: urology, dermatology,

otolaryngology, ophthalmology, cardiology, and anesthesiology. While we use consultants in these specialties infrequently, their value to the service will be inestimable at such times as we are up against a case needing a high order of professional talent and the patient cannot be moved for one reason or another to a general hospital.

I believe that, by having a large group of consultants available, we are promoting good feeling among a larger group of the civil medical profession, which is so essential at this time to the future Medical Department of the Army.

In summarizing, let us state that the civilian consultant program is of inestimable value to Army medicine not only from the purely professional aspect, but from the morale factor as well. The younger officers look forward with great enthusiasm to the consultants' visits. I believe that the program has been a stimulus to the procurement program of the Army and the close liaison and cooperation between civil medicine and Army medicine is exceedingly beneficial to all concerned.

In the near future, as the shortage of Medical Corps officers become more and more acute, it is probable that we shall have to rely more and more on our civilian consultants. Therefore, we are attempting constantly to expand our program in the First Army Area and are endeavoring to secure at least three competent consultants in every specialty. In this connection we are attempting to obtain civilian dental consultants highly trained in oral surgery.

I should again like to emphasize that one of the best methods of maintaining a cordial relationship with these consultants is through close personal relationship and that the surgeon and his assistants should exercise every effort to save the consultants from harassing and administrative details and arrange promptly for their transportation, accommodations, and pay.

In closing, I should like to say that our consultants have been splendid in meeting our requests for visits to our hospitals. Likewise, we have had the finest cooperation from General Bliss, Colonel Cole, Colonel Blitch, and the entire staff of The Surgeon General's Office.

DISCUSSION

COLONEL COLE: Well, I've enjoyed very much the remarks which General Denit has made and there are two or three points that the General has brought out which I think should be re-emphasized. One especially is the cordial relationship and the cordial cooperation which we are trying to foster between the Medical Corps of the Army and our civilian consultants and civil medicine in general. One of the finest ways to do this of course is through our consultants. General Denit fortunately has almost an unlimited number of highly qualified men in practically every specialty on whom he can call, and he has his consultant program set up so that practically every specialty is covered by a very good high-powered consultant. As time goes on we can visualize that this consultant program may get smaller as we get more men in the Army who are qualified and who become specialists before the board. But there is one point that I think we should never forget--the fostering of the cordial relationship with civil medicine through our consultant program. I think this is one of the finest means we have, as General Denit brought out in his talk, to put over to the civilian practitioner and civilian specialists in general just what the problems are in the Army with which we have to cope now and in the future. During the war we had a galaxy, one might say, of highly qualified specialists. Well, we don't have that any more, and only through cooperation and work and engendering this feeling of good will with our civilian confrerees and through our consultants can we keep up this good relationship. There is one thing I would like to ask of General Denit and of all surgeons--we would like to have in this office an outline of the schedule of the teaching program. We don't particularly care about the individual subjects that are carried on in that program, but we should like to have sent in to us once each month an outline of the schedule, for example, which you conduct at Fort Jay. We think it would be very illuminating, and it may be something from which we can base future planning for other army areas. I should like to emphasize also the emergency consultation. That point has been brought up time and time again in our isolated areas. What can they do in case of an emergency consultation? Well, if they have these consultants already appointed it is easy to get one of these men to come out and not only see the patient once but follow the case up and render assistance over quite a period of time. I think that is very important. Another question which General Denit touched on but did not go into very fully, and which comes up from time to time, is the use of consultants in treatment of civilian dependents. Now in our training program we have a program set up for the training of obstetricians and gynecologists. That entire program is predicated on care of dependents. Soldiers do not give birth to children, but their dependents do, and for that reason I think we have ample ground on which we can back up any call for emergency treatment or the use of consultants in handling civilian dependents who are bona fide patients in our Army hospitals.

GENERAL BLISS: Open discussion now, which I assume will concern consultants in the army areas rather than the consultants that have to do with our general hospitals. I'd like to hear from you.

COLONEL WILLIAMS: I have one little bit of discussion and one question to put to the conference. The first is discussion not about civilian consultants but about specializing in the younger medical officers. We built up our medical staffs in our stations and station hospitals as well rounded as we could to cover the various medical specialities, and the bulk of those people are of course ASTP's. Now they are starting to terminate their service with the Army and month by month we lose them. This immediately throws our staffs out of balance. I have in mind one small station hospital which will lose eight out of thirteen medical officers in the next four months. Nothing unusual about that, but when we get through we have nothing in the staffs to cover internal medicine, EENT, and laboratory as very important parts of that hospital. Now my point is that we are going to take the attitude in our Army that those men of course are not specialists at all. They have had abbreviated internships and many of them rather limited, as, for instance, a man taking a straight surgical internship. We recognize that he is not a specialist in any way at all, but that he is interested in surgery above other branches. But, as we go down in strength and upset the balance of our staffs, we're going to ask these people to step out beyond their announced interests and be doctors and take care of the patients that we have. The only alternative would be this business of shifting a youngster from Sill to New Orleans and from New Orleans to Bliss and so forth. They are not specialists and the shift simply means that they would continue to get the service that they desire, but balanced against the loss of time, the money spent, and the difficulties they would have in finding a home in a new station. We're not going to do that; we are going to ask them to broaden out beyond announced interests.

The other thing has to do with the annual physical this year, and consultations. The tendency has been very marked in the last few years of bringing in to maximum use the specialists in doing our physical examinations, particularly the annual physical. That's even more marked in the orders for this year's physical. Our problem is going to be that in most of our stations we'll have only one or two regular medical officers. Those men are not specialists. The rest of the medical service will be young ASTP's. Now, when we require that any abnormality be submitted for consultation, I'm faced with one of two things: either the consultation is of only moderate value or there is the very strong possibility that there will be a tendency, conscious or unconscious, to mark minor abnormalities as normal in order to avoid the inconvenience of getting that officer examined by a consultant. We do not have very many consultants in my area. We have only five, and we can't ask them to go hundreds of miles and see a single individual. We are going to have a problem at stations of fifty, sixty, or a hundred officers for annual physical and a hospital staff not capable of giving the really valuable consultations required by the examination. We also have the problem, which I think all army areas have, of the recruiting service. Recruiting has become so important that these men are absolutely sacred. They can't

be picked-up and moved around. We can't send them within a reasonable time to a general hospital for an examination. We cannot send the examiners to them to be able to give them all the consultations they need. That last point is my question, if there is any happy solution I would like to have it.

COLONEL RUDOLPH: I have a question to ask. Do you want a monthly report from the larger station hospitals that are not necessarily indicated as teaching hospitals?

COLONEL COLE: No, we don't require monthly reports from the large station hospitals except this: if you are carrying out, as General Denit is at Ft. Jay, a regular teaching program in which the consultants participate and in which you have a regularly scheduled teaching program, then we should like to have the reports come in here, at least a schedule of your teaching program. Does that answer your question Colonel Rudolph?

COLONEL RUDOLPH: Yes.

COLONEL BILLICK: I have come to this conference with two desires in mind, one is to have a group of consultants that I classify as teaching consultants in my station hospitals. I also want consultants that I can call in, local consultants, living near Leavenworth, living near Riley, living near Ft. Sheridan and near Carson, that I can call in for emergencies. I think we have forgotten one thing about the OB consultants and the consultant for dependents. It is my understanding that government funds do not exist to call in such consultants. In other words, I can call a consultant any time I care to for a soldier but I cannot call him in for a civilian. I had a very celebrated case just three weeks ago at Fort Sheridan. The daughter of a Lieutenant General, the chief of a service in the Department of the Army. Colonel Dowell was absent on leave when she decided to precipitate her emergency, and I didn't know that the young lady was in the hospital until the next morning or I would have gone over to assist. An ASTP boy took care of her. I have no OB consultants on my list. She got along very nicely. The premature child was put into an incubator and the last word I heard when I left Chicago last Saturday was that he had gained back his birth weight. I'd very much like to have OB consultants, dermatologists, and pediatricians. But, frankly, I don't think we have money to pay them. If we have, I would like to be enlightened. I was asked to appoint an ophthalmologist. I have one ophthalmologist who is being taken away from me; he is at Fort Leavenworth. I have no other ophthalmologist in the Fifth Army and, frankly, I don't know what this consultant in ophthalmology would do when he went around my station hospitals except to give me an adverse report of the ophthalmology service. I would like to have an ophthalmolgist located near these station hospitals that I can call in to take care of emergency cases or to consult. It is my understanding that these consultants are to tour the hospitals and advise and supervise the service in that hospital. And I would like the program be expanded much further than that.

Since Colonel Williams brought up the recruiting program I should like to speak of that, too. It's the plan of the Fifth Army to use

certain centers within our area for recruiting soldiers, and, since I don't have the doctors, we are going to employ civilian doctors. We are going to examine these recruits except for the x-ray of the chest. The boy will hold his right hand up, be sworn in, become a soldier, and then he will arrive at his training center, and there he will receive his x-ray of the chest. And I am afraid some of them are going to turn up with active tuberculosis. As a matter of fact, I have one case already who has done just that. I want the members of the conference to understand that I fully agree with the consultants program, but I don't see how I can employ it within my army area as widespread as it is, and when my five Army consultants that I now have under my control are any place but in Chicago. I even have one whose residence I believe is in Cleveland, Ohio, in another army area. And I would like to be able to appoint individuals locally and have them locally around the station hospitals where they can be employed.

GENERAL BLISS: I guess Colonel Cole will be here in a moment, but there is actually no question about the availability of consultants for taking care of any patients who are in the hospital. Is that clear? No question whatsoever, legally, financially, or otherwise. That's what the consultants are for: to take care of the patients who are in our hospitals. Any patient who is authorized to get into one of our hospitals is authorized to have the best care that can be given or the same care which is given to everyone else. As I said before, my conception of the consultants is that each hospital should be covered by a consultant who does not go there necessarily when he is called in to see some interesting patient, but who has the responsibility of telling the surgeon that the service is or is not properly covered at that hospital. He goes to the hospital as often as the surgeon may want him to or as often as they jointly think it is necessary; he does anything or everything which may be done, not just being called in as a consultant. This consultant system is devised and thought out on an entirely different basis than the old conception of calling in the consultant when you needed him to help on an operation or on a specific case. Someone else can answer the question about the consultants for annual physicals and all that.

COLONEL COLE: I am sure that General Bliss has answered most of your questions, Colonel Billick. The very fact that we have these patients, that they're entitled to be treated in that hospital, is enough evidence that they can be seen and be taken care of by consultants. Now we can go right back to our teaching hospitals. We have OB and GYN services set up there as I said before. These are all, or at least the majority of them are, and they are taken care of, seen, consulted over, and their treatment as is asked for is directed and taken care of by the consultants. Now as to having all your consultants appointed in Chicago, I think that's fallacious. I think you should appoint your consultants in the areas near the hospital which you wish them to serve. At Fort Sheridan, for instance, you can appoint consultants from those towns near Sheridan, if they are available. I think Highland Park and some of those other towns up there certainly must have consultants of the caliber

which you would desire as consultants. I am sure they are present in Colorado Springs. Now I would like to read from AR 40-10, Change 5, paragraph 4e, and this is in answer to your question that the consultants tour the hospitals and advise the commanding officer of what is going on in his hospital: "They may be called upon by the commanding officer for any professional service or advice or appropriate professional assistance he may desire of them." Assistance can mean operating, or anything else, as we interpret it. I think that there is no reason why you can't, under existing regulations, appoint consultants for your station hospitals in the areas, provided they are available near the hospital involved.

COLONEL RICE: There is one, there are a number of points that are very important on these selections of Army consultants; one of them is to attempt to appoint them in areas where the hospital is located in order that they will be able to make the trip. Most of them do not care to take long trips, because they are busy people in their communities. Therefore, if they can be appointed near those hospitals or in centers where hospitals are located, you will get more service out of them than you will if you try to appoint them in one locality and ask them to make trips that required three or four days. Another point on the teaching consultants I believe worthy of comment is: when these teaching consultants arrive at the hospital they should come at a certain appointed time so that the chief of service concerned can have the interesting cases ready and the staff there for these cases. Often-times, the consultant reports in the hospital and nothing has been prepared for him as far as the teaching side is concerned. So he makes ward rounds and doesn't do very much so far as teaching is concerned. Now your chiefs of service should be responsible to see that these clinics are organized and, when the consultant arrives, that they have not only the patients that they are going to see, but also the staff is available and there at the time so that they can get the most out of these conferences. I have used consultants to see civilian patients. I'd like consultants also to come in and operate on patients. We have seventeen of them. We have also had consultants go from Baltimore to outlying stations to examine psychiatric patients on whom there was a question of disposition. I thought that was the just thing to do. General Denit mentioned one point that struck me between the eyes, and that is that the army surgeon should have a closer relationship, a more friendly relationship between himself and his consultants. He should know them personally. If you don't know them personally it isn't long until they lose interest; they don't accept your invitations to visit your hospitals or they find excuses not to go. Whereas, if they know you personally I think they will do it more readily than if you don't know them.

GENERAL DENIT: We have written a letter, and I have a mimeographed copy of it here, to each one of our people. I won't go into the preamble but we state that it is desired that the following be adopted as a protocol during the visits of the consultants. Commanding officers concerned to meet the consultant and extend him all possible courtesies and acquaint

him with the general problems confronting the installation. The chief of service concerned will insure that all patients on his service have been carefully worked up and ready for presentation. As many members as possible of the particular service make ward rounds with consultants. Work should be kept at a minimum during the surgical consultant's visit in order to allow the maximum number of officers to be present on the ward rounds, unless the consultant specifically requests other arrangements. On the completion of the ward rounds we like a general discussion held in which the consultant may summarize his day's findings, etc. We try to call the consultant up on the 'phone and tell him exactly what time he leaves and exactly what time he is going to arrive at the hospital, or we send him a TWX and tell him. That's the protocol we have, to keep from wasting time. Now I don't believe in these one- or two-hour visits for $50.00 a day. We try to arrange it so that they will leave New York early and get down there in time to stay practically a whole day. Two hours for $50.00 is a little bit too much for me, and we're not going to encourage that kind of consultation in the hospitals.

B. THE CONSULTANT PROGRAM,
JEFFERSON GENERAL HOSPITAL ..... Colonel Dean F. Winn

General Bliss and Gentlemen, we're a little behind time so I will read some of this rather rapidly in order to cover the field. We made mistakes when we began to implement this program, because in the beginning it was a question of trial and error. We had no precedents by which we could govern our actions. Although we had circular 87, which covered certain requirements, it was by no means an answer to all the problems which arose. It was evident from the start that a coordinator on the commanding officer's staff would be essential. Although it was considered desirable to provide a fulltime medical officer of senior grade to perform this duty, no officer with the necessary qualifications was then or has since been available. The job was therefore given to the executive officer as an additional duty, who, with an administrative officer as an assistant, was in charge of all hospital training activities. Although this plan has worked well, it is not entirely satisfactory, because the many and varied responsibilities of an executive officer prohibit his keeping in sufficiently close contact with all the phases of the program. A move to improve this shortcoming has recently been adopted. One experienced medical officer from each service has been selected by each chief of service to assist the coordinating officer, and the chief duties of these individuals are to assist in preparing for residents and interns on their respective services, schedules which will permit the over-all schedule to operate without conflict and which will insure a maximum of time for residents to use in attention to patients and bedside instruction. These officers also are expected to acquaint themselves with the various opportunities afforded in the local medical schools for extra-curricular training and to coordinate the utilization of these facilities by residents and interns. They are further expected to maintain close liaison with other services in the hospital so that each chief of service may keep informed of any training activities or interesting and instructive cases in the various wards that may be of value to his own trainees. They also are used to organize these conferences so that there is no delay in getting patients to the place of meeting, see that the interns and residents on the job have the cases to present, and keep some kind of informal record of attendance of consultants. It is believed that such a system would be useful even if the program coordinator is employed as a fulltime officer.

The education committee of course was set up in the prescribed manner with the chiefs of services, commanding officer, the executive officer, and three civilian consultants as members. The latter are Dr. Carleton Mathewson, Professor of Surgery, at Stanford; Dr. Kerr, Professor of Surgery, California;

and Dr. Bowman, Professor of Psychiatry, California. The committee early reached the conclusion that the utilization of consultants should be left to the discretion of the chiefs of services with general supervision by the committee as to the adequacy of their use. This system has been followed. However, as a matter of hindsight, it is my personal opinion that the more detailed consideration of the method of utilization of consultants by the education committee would have been advisable and will be instituted. It is desired to stress that the chiefs of services have the real responsibility in setting up and executing the program. The chief of service must constantly ask himself, and he must ask his consultant, how he can improve his particular program. That is done and it has resulted in drawing out some valuable suggestions. Another thing that the chief of service must do is to participate actively in this program himself. We require the chiefs of service always to get up and talk and to prepare to talk when one of their cases is being brought up. But I feel that the chiefs of services should not be overshadowed by any consultant. We realize that they are much more high-powered, but we've got the obligation to instill respect for the opinion of the chief of service on the part of his juniors, and we've got to get him accustomed to teaching and standing on his feet and talking. So I think it's very important.

It is the firm opinion of the education committee at Letterman that implementation of the program must be decentralized to the training hospitals and should in no way preclude full compliance with the intent and spirit of the Surgeon General's directives. There are many factors involved which support this opinion. Among these may be mentioned local physical plant, organizational framework of the hospitals, the type and qualifications of assigned personnel who participate and/or contribute, and the personalities of the attending staff and their availability, interest, and effectiveness in teaching. The variations in the problems inherent to each professional service have made for some apparent lack of uniformity in our system of utilization of consultants. And I will rapidly explain how we use them on the various services.

On the surgical service two general surgeons have been found sufficient to conduct ward rounds, clinics, round-table discussions, etc., and to assist in a teaching capacity during surgical operations. Both of these men are fulltime professors at their medical school, and thus are experienced and excellent teachers. They have demonstrated a keen interest in the program and a positive intention to turn out well-trained surgeons and successful specialty board candidates. These consultants are Dr. Carleton Mathewson, Professor of Surgery at Stanford, and his assistant, Dr. Cohn. They have made it possible for our residents,

interns, and staff to participate in surgical rounds, in a cancer conference, and x-ray conference each Wednesday morning at San Francisco County Hospital, activities which these consultants themselves conduct and which have supplemented immeasurably our own clinic facilities--especially regarding the acute cases that we sometimes have a shortage of in the general hospitals. Both of these consultants are unselfish and untiring in their contribution to our program. While they have been asked from time to time to perform certain serious or unusual surgery, they have ordinarily acted as teaching assistants to the staff officers and the residents. In this capacity they have been outstandingly helpful and have given freely of their time and patience. During the year, Dr. Mathewson has given many nightly lectures on timely subjects and at present is presiding over a weekly quiz course of round-table discussions based on questions previously used on examinations of candidates for specialty board certification. This has proved of definite value and stimulation to study to residents and staff members alike. They now are supplementing this quiz with the demonstration of preserved gross specimens and appropriate slides so that the candidates will become accustomed to seeing specimens preserved in formalin as they see them on the board examinations.

We have about fourteen consultant surgeons, in addition to the two mentioned, who are used for ward rounds, instruction, special teaching clinics, and for assistance in operative surgery in the sub-specialties of neurosurgery, vascular surgery, obstetrics and gynecology, urology, proctology, thoracic surgery, and anesthesiology. These consultants have entered into our program eagerly and with enthusiasm. Those on urology have been particularly helpful in supplementing our clinics with their private cases and in furthering our civilian relationships. The same can be said of the consultants in obstetrics and the other sub-specialties.

On the orthopedic service we have seven consultants. Two of these alternate weekly in a two-hour clinic on various orthopedic subjects with presentation of illustrative cases by the residents. Another has teaching rounds one afternoon each week, and occasionally participates in operations. Dr. Sterling Bunnell and his assistant conduct teaching rounds one afternoon each week on hand and plastic cases and participate in operations at times. Two instructors in anatomy from the University of California staff are used one evening weekly to supervise a course in anatomy of the extremities, including cadaver dissection by residents. A lecture and demonstration also is given by these consultants. Each Saturday from eight to nine A.M. residents visit the following hospitals in rotation: University of California, Children's Hospital, Franklin

Hospital, Shriner's Hospital, San Francisco Hospital, and St. Mary's Hospital. A program is presented by the staffs of these hospitals covering various orthopedic problems with presentation of cases.

On the medical service fifteen consultants are utilized. Four of these make teaching ward rounds on the general medical wards once weekly; one of these also gives a forty-five minute lecture after a five minute case presentation once weekly. Another of this group supplements his ward rounds by lectures on a special subject, such as thyroid disease, from time to time. Four medical consultants confine their teaching to weekly clinics on gastroenterology and gastroscopic examinations, cardiology, endocrinology, and rheumatology, except that the consultant in rheumatology spends an additional half day weekly in ward rounds. Dr. Kerr, Professor of Medicine, at the University of California contributes a monthly teaching clinic on special cases. Dr. Kerr takes an active interest in our teaching program and has made available to us many of the teaching clinics at the University of California. He has been instrumental in our procuring three exceptional young officers (AUS) who have been singularly valuable in our resident training. Dr. Kerr's long experience in medical education makes him of particular value on our staff. The four consultants in dermatology contribute fifteen hours to this section--three hours, five days per week. One is assigned to teaching ward rounds and the other three teach in the wards and outpatient clinics. They are headed up by Dr. Frederic G. Novy, a very fine skin man on whom we depend a good deal for his advice and recommendations. The resident, the only one we have in dermatology spends seven hours weekly at the University of California.

The laboratory service has two tissue pathologists and one PhD in biochemistry as consultants. The latter has been used for a series of lectures for training courses in anesthesia and for some fifteen two-hour lectures to the staff and student officers on biochemical processes. One of the two consultants in tissue pathology is used exclusively for lectures and demonstrations on surgical pathology. Weekly meetings have been held for approximately four months utilizing the surgical study sets supplied by the Army Institute of Pathology. On completion of this survey of general surgical pathology, it is contemplated starting a series of weekly lectures lasting approximately four months each in the various specialties such as urological pathology, etc. Prior to introducing this training, our staff officers had very limited formal direction in their efforts to review pathology in preparation of board examinations. The second consultant in tissue pathology is a very busy man and has found it difficult to give us very much time. At present he

attends one weekly departmental conference in the pathology section in which controversial cases, both autopsy and surgical, are presented for his comments and suggestions.

On the neuropsychiatric service, the more or less unofficial director of the consultant group is Dr. Karl M. Bowman, professor of Psychiatry at California and director of the Langley Porter Clinic. There are two additional consultants in psychiatry; one in psychiatry and psychoanalysis; one in neurology and electroencephalography; and one in neuropathology and neuroanatomy. All of these consultants occupy responsible teaching positions at either California or Stanford. A total of approximately twenty hours weekly is spent by these consultants in a teaching capacity at the hospital. In addition, the residents attend the Langley Porter Clinic once weekly for a conference of an hour and a half duration, the combined neurological-neurosurgical clinic of one hour's duration at California, and the Mt. Zion Hospital Clinic, one hour weekly. Plans are under way for the appointment of a consultant to implement teaching of dynamic psychology and psychiatry that is psychoanalytic, and a consultant in clinical psychology. In general, consultants on this service are utilized in both didactic and clinical teaching capacities, i.e., lectures and actual work with patients, in the diagnosis and treatment of difficult unusual cases, as advisors to the chief of service and sections, and for highly technical activities such as interpretation of unusual electroencephalograms. For the most part, their time is devoted to patients presented in clinics—patients chosen for their teaching value in diagnosis and treatment. The psychoanalysts devote part of their time to a general clinic, reserving the last hour of each session for individual work with the one resident.

The consultants advise the chief of service on his request as to the progress of residents in the courses which the individual consultant teaches. In general it may be said that the teaching consultants are an integral part of the service. The cordial personal relationship which has so far existed between the consultants and chiefs of service has aided immeasurably in arranging outside clinics and maintaining good relationships with local specialists in general.

In the x-ray service two consultants are used. One of these devotes two hours once a week. The other spends about two hours once every two weeks. This amount of time has proved ample in the opinion of the chief of service. One of the principal benefits of the consultant program in the radiological service has been the injection of fresh thoughts into diagnostic and therapy procedures. This is stimulating to the entire staff and has a most salutary effect in keeping the staff abreast of current developments in the field.

In otolaryngology there are two consultants. One of these has teaching ward rounds from eight to twelve one day each week. The other has a clinic, as well as ward rounds, one afternoon each week. At the end of these periods each consultant gives an informal lecture to the residents and other interested staff members on subjects chosen by the attending staff and the chief of service and designed for comprehensive coverage. Each of the consultants has been a participant in difficult surgery when indicated. One night a week residents have attended an otolaryngology conference at the University of California.

In opthalmology, four consultants are used. Doctor Frederick Cordes, Professor of Ophthalmology at California gives a clinic once every two weeks at which interesting inpatients and outpatients are discussed. Two other consultants conduct morning and afternoon weekly clinics. Another consultant attends the ophthalmology clinic one morning every other week teaching pathology to the residents and other trainees. Each attending surgeon has given one lecture a week covering the most important aspects of ophthalmology. The attending staff on this service has rendered helpful advice to the chief of service in regard to the procurement of drugs and instruments. They invite the residents and other members of the staff to special meetings at both the local schools and have kept us abreast of current developments at both institutions. They have all shown a great interest in the work going on at Letterman and have made many helpful suggestions concerning teaching and the treatment of patients.

In physical medicine we have only one consultant, who spends about two or more hours a week depending on the number of patients to be seen. All the medical officers including the residents of course are invited to attend this conference, but it is not compulsory. The consultant, Dr. Northway, has arranged to give a series of lectures to the entire staff during the current month.

In the dental service eight consultants are used, all of whom are part or full time instructors in local schools. Primarily the consultants are employed in presenting the didactic phases of the teaching program and in the supervision of the applicatory work of the interns. Treatment of patients by consultants is limited to the most difficult and unusual cases which are demonstrated to the interns and staff. Dental interns participate in the following conferences at the University of California of Dentistry: Four hours every other week in roentgenology; two hours each week in peridontia; two hours each week in oral pathology. We might say that deans at both of these dental schools are very enthusiastic about this program and are rendering a great deal of support.

General Observations--In presenting our problem to the attending staff the point has been emphasized that our aim is to turn out well-trained men and to make our training program good enough to attract men to the Army as a career. The educational committee has felt that the clinical material available must be carefully evaluated and dilution of our facilities avoided. It has been the concern of the committee that the tendency to overload the program by a desire to prepare a large number of officers for specialty boards or by the recurring assignment of groups of officers for short-time training periods might seriously jeopardize its success. This is especially true as long as staff officers who are actively preparing for their specialty boards must share in the clinical facilities. The morale of the attending staff, especially those members who have developed a keen interest in helping to put the program over, could easily be impaired if they have reason to believe that overloading is seriously interfering with adequate training and its successful prosecution by a project the practicability of which may still be a question in their minds. Certainly the residents are not going to be satisfied if clinical material is diluted and inadequate.

Now in a personal communication to General Armstrong he asked me to discuss the following aspects of this program: First the general administration, including appointment and control and coordination of civilian consultants.

The general administration of the consultant program has already been touched on. Consultants are required to sign in at headquarters each time they visit the hospital. They are not required to sign out. This would not be desirable or necessary. At the end of each pay period the Adjutant certifies to the civilian payroll officer as to the number of visits each consultant has made. Payrolls are prepared with this certificate as a basis, and checks are mailed to the consultants. No minimum hours of attendance are required. In this connection, and with reference to the chart that Colonel Cole has distributed, I am very sure that those hours are largely guesswork, because I don't believe we were required to keep this information. The chief of service concerned now is being required to maintain a record of the type and number of hours of instruction given. This has been found to be necessary in order to compile reports recently instituted by The Surgeon General's Office.

We are greatly indebted to Dr. Frank R. Berry, one of the consultants to The Surgeon General, for his assistance in the selection of our original attending staff. In collaboration with Dr. Carleton Mathewson, he was instrumental in providing an exceptionally fine group of teachers. Most recent appointments have been made on the recommendation of the hospital commander

after consultation with the chiefs of services and the civilian members of the education committee. However, there have been some appointments made direct by The Surgeon General's Office. It is a well-known fact that there are outstanding men in the medical schools who have made recognized contributions to medicine and medical literature but who are not qualified as teachers. Their appointments to the attending staff should be avoided. It is our opinion that all recommendations for appointment should originate with the hospital commander. Selections have not been based particularly on how outstanding the physicians or surgeons were, or how nationally known they were, but on whether they have proved themselves as teachers in the local universities and how conscientious they would prove to be at teaching their specialties in the Army training program. The policy of appointment of consultants on a yearly basis should be continued, and, further, that appointments be renewed only after the local education committee has passed such renewal. It is further believed that the reactions of the residents to the teaching qualifications of consultants should bear some weight in making any final judgment. The consultant staff should be thoroughly aware that they are under constant scrutiny, and that they cannot expect their services to be continued from year to year unless they put forth their best efforts toward participation in the program. Ultimate control over consultants should at all times be exercised by the commanding officer through the education committee.

The second point he wanted me to discuss was utilization in general, including their use in the treatment of patients, teaching and consultation, as professional advisors to me, and in evaluation of professional personnel. Utilization in general should devolve upon the chiefs of service under the general supervision of the education committee. This should include the privilege of rotating certain consultants on different sections of the service when deemed advisable. Consultants should understand that the clinical material with which they are dealing must not be used for their own personal gain but should be utilized to the maximum for the teaching of residents and interns just as would an instructor in a medical school. Surgical consultants should impart their knowledge by acting as assistants in operations rather than as the operators. Their experience and knowledge can best be taken advantage of if they participate with the staff surgeons and with the residents as the latter become qualified to perform operations. It is recognized of course that there are some difficult and unusual operative procedures in which it is desirable to have the consultant actually perform the operation with the assistance of the hospital staff. Consultants should be used both in teaching ward rounds capacity and for holding teaching clinics.

Chiefs of services should be alert to see that the consultant's time is fully utilized throughout the period of his visit. It is not considered advisable to have different consultants conduct regular teaching ward rounds on the same patients. Our experience indicates that teaching clinics that are frequently held in ward dayrooms and to which patients are carried for presentation by their senior officers have been of especial value. It is not believed that the attendance at such clinics should be considered as unwarrantably taking the time of residents and interns from bedside instruction or actual work with patients. Everybody here, I am sure, has made ward rounds with large groups of people and the fellow on the periphery doesn't even hear what's said and he loses interest. And I don't think that type of teaching is nearly as good as the teaching clinics. If you have only four students, then ward rounds are all right. They are all right anyway, but there is a better way out. It is rare that a member of the attending staff is used in a purely consultant capacity. However, this is resorted to in the case of certain individuals such as a dean of a medical school, whose intangible value to the program is great, but who has not been able to devote a regular period of time to the program. We have been very delighted to have persuaded the Dean of Stanford to accept the consultant's position, and I believe next week the Dean of California will also consent. We need these people very badly, I think, to influence our students. I think they should know what the program is all about; they should believe in it. I don't believe that either one of these deans believed in it very much until General Armstrong told them about it; I think he convinced those two men. We want somebody in those positions, the deans of medical schools, who will certainly give our staff the right sort of goal for our program. The consultants are encouraged to consult with the chiefs of the services and the commanding officer in an advisory capacity. While the most cordial relationship has been maintained with consultants, the suggestion of The Surgeon General regarding more frequent get togethers is thoroughly concurred in. We have invited these men to join our officers' club; most of them have joined it. Many of them we call by their first names and they call our men by their first names. So there has been very close personal relationship with practically all of them.

The consultants have also been helpful in injecting the hospital personnel into the affairs of the community. They have encouraged attendance at the County Medical Society meetings and other professional gatherings. It is believed that they should encourage and assist medical officers in presenting papers at professional meetings and in writing papers for publication. Through these undertakings we can better put across to the civilian community what actually is going on in our training hospitals. Just next week Dr. Mathewson has arranged for an

invitation for Colonel Heaton, the chief of the surgical service, to go to Los Angeles and present a paper to a very select group of Pacific Coast surgeons. He does it because he wants to further Heaton's reputation in the community.

Evaluation of professional personnel by consultants has been conducted in an informal manner. We talk about these men a good deal, but a formal statement from consultants is now being required. In reviewing the grades of student officers, the education committee has given full consideration to the opinions of the attending staff members.

The third point that General Armstrong asked me to discuss was their use as aides in the procurement program and in the maintenance of good relations with civilian medicine. It is difficult to evaluate at this time the aid consultants have rendered in the procurement program. Dr. Mathewson informs me that medical students are already asking him for advice as to the Army and what the Army has to offer. It is becoming known to students through their contact with consultants that the Army has a training program, and it is believed that as time goes on more and more of the students will manifest an interest and be advised to take advantage of it. In line with one of the remarks that General Armstrong made, Dr. Mathewson said that some former young officers seeking civilian hospital residencies are reported to have rejected any suggestion for the pursuit of an Army career because of unfortunate previous assignments to duties which they felt might just as well have been performed by administrative officers. And he cited several cases of which he has personal knowledge. It is believed that the consultants will prove a valuable aid to procurement as our program becomes more firmly organized and our consultants more completely sold on the idea and convinced of the sincerity of the Army in making a professional career possible.

The fourth point was any suggestions you might have relative to improving the program including measures of economy that might be taken without jeopardizing the program. In this connection the appointment of one consultant as coordinator should be discussed. Well, I think one way we can improve this program is to go along with those in the hospitals right now, but I think we must be sure we assign chiefs of services who are teachers and are interested in teaching; not just good operators. Try to make these residency assignments as permanent as possible so that the man doesn't get just one year and is then interrupted. Establish formal teaching programs in all hospitals. Everybody is familiar with the tremendous amount of clinical material that we have wasted in our Army hospitals. I am guilty myself over many years. We had a little two by four teaching program, but

we didn't actually have a formal program. As a measure of economy it might be well for the education committees to review the consultant staff from time to time with the idea of eliminating some consultants in sub-specialties and employing those remaining to better advantage. During the past year considerable pressure was put on hospital commanders by The Surgeon General's Office to increase the number of consultants. It is possible that this has brought about an excessive number in a few isolated instances.

The appointment of one consultant as coordinator is not considered favorably. This opinion is based on the difficulties which would be encountered because of personality clashes, the existence of civilian cliques, the extreme individuality common to doctors, and the fact that consultants at least in certain instances are drawn from two rival school faculties. It is further felt that the coordination of consultants is inherently a responsibility of the commanding officer of a military hospital. It is believed that the chief of service should act as the coordinator of the consultants on his own service.

In conclusion, may I with propriety make these observations. It is not believed that the utilization of civilian consultants should be permitted to inhibit initiative and direct decision on the part of Army medical officers. Medical officers must be alert to maintain responsibility for the care of patients and not be expected or permitted to delegate this to consultants. Medical officers should be encouraged to maintain reliance in consultation between staff officers and not permit this important staff coordination to suffer as a result of extra-staff contributions. And finally, it is felt that the Army must stand on its own feet in any program. This can be accomplished and the important contribution of civilian consultants fully utilized provided harmonious consultant relationship is maintained. Teaching staff officers should avoid board fever in their relation with consultants and should preserve the dignity of Army medicine by a receptive attitude and by an attitude of equality in any discussion. I believe that most of the consultants subscribe to and promote the above as a basic concept.

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DISCUSSION

GENERAL BLISS: Colonel Winn has said an enormous amount there and when this is transcribed it will give us one of the most excellent programs that is going on in any of our general hospitals and I hope that you will all read it carefully. The program which is going on at Letterman is excellent in every way shape and manner.

COLONEL COLE: This very fine report which Colonel Winn has read of the activities of the consultant program at Letterman Hospital needs no discussion. I think it is a very good example of the program; he has covered everything in almost minute detail. And as General Bliss said, when this is printed it will be well worth reading by everyone connected with this consultant program.

There are one or two questions though that I would like to touch on. One is the problem of appointing consultants direct from this office. As far as I know, in surgery there have been two direct appointments made to Letterman Hospital from this office. One was by order of The Surgeon General himself, the previous one, and the other because we wanted to hold him for an overseas assignment where we are now processing to send him in the very near future. As I said before, it has been the policy of the consultants' branches in this office not to appoint consultants to any installation until that installation comes forward with a recommendation. We have tried to live up religously to that. In the beginning there were some exceptions to it because we had to work rather rapidly and had to pick up consultants where we could get them and take whom we could get. But I think now you'll find that practically all, with reservation--because occasionally we get one for whom we receive a direct order to report--are appointed only on the recommendation of the hospital. But that is a very excentional case. General Bliss, there have been two of our gentlemen on the program this morning who have stated that they don't think that consultant should be appointed to administer the work of the consultants, so with that in view I think we shall have to leave that question open for discussion at a later time or until such time as the decision can be arrived at on that particular point. Colonel Winn brought up in his paper that there are consultants who have been appointed and who have been carefully checked by the commanding officer and his educational committee, but who during the course of the year are found not to "fill the bill" for which they were appointed. It is rather difficult to come out in the middle of the year and tell Dr. Smith, "Well we don't want you as a consultant anymore". He'll want to know why and you'll have to tell him, which will break down all the good feeling which we have built up. So at the end of the year, as I have stated in my previous talk, when recommendations are asked from the hospitals and the army areas as to the names of those consultants who are now on their staff

whom they wish reappointed, that is the time to state that so-and-so is not recommended for reappointment. Thus we can drop him out without too much trouble, and it will be handled from this end without any reflection on your department.

There was another thing brought up which has been touched on once or twice and that is the evaulation of the residents each quarter, or each time they are evaulated. This has been done by the educational committee with the commanding officer of the hospital on the recommendations of the consultants and the recommendations of the chiefs of services. It is believed by Col. Duke of the Education and Training Division here that an additional evaulation should be made by the consultant involved. For instance, if we have a resident in orthopedic surgery, an individual evaluation should be made by the consultant who has had this man under close observation during the period that this report covers. That would be sent in through the education committee, be evaulated by them, and be an additional evaulation sent in with those made by the committee.

I think Colonel Winn is very fortunate in his geographical position because there are two very fine medical schools from which he can draw consultants. Most of our general hospitals have one, some of them none, and it is extremely difficult in some of our station and general hospitals to get qualified teaching consultants locally. They just aren't there. We have to draw them from over a great distance. Colonel Winn has two fine schools to draw from; Fitzsimons has one; and Walter Reed has two here. Brooke has none. It is extremely difficult in those places where there is not this abundance of material on which to draw to get the type of consultant whom we wish to carry on this program.

COLONEL WINN: I didn't mean in my remark to cast aspersion on The Surgeon General's office. I still think that's a bad idea to come from any other source but local. In reference to personal relationships with these consultants I would like to add that it is my practice to have everyone of these new consultants come to see me and we can go over this program very carefully. They are made to understand that as far as possible they are members of our staff, and we expect them to consult with us, with me, and with the chief of the service, to come in and make any comments or suggestions they want and we will give these every consideration. Occasionally, if you keep your ear to the ground, you will hear stories going around. Someone was quoted as saying that something is wrong with our medical service program, but he hadn't come in and told me anything about it. As soon as I heard that I sent for this gentleman and sat down and told him again what we expected from him in the way of cooperation, that we don't want him to be dissatisfied and spreading news around that things aren't

exactly as they should be. It is through these personal conferences and in my meeting them around the hospital, shaking hands with them, and asking them about various things that we keep very close contact with them. The meetings that were proposed in a letter that recently came from this office and which I think were all right, are going to take the place of this activity which I've described as personal relationship.

As to the consultant coordinator, it was the consensus of all of the consultants with whom I've talked that this would not be a good idea. They thought that it would create friction and destroy some of the good morale we now held. There are some people there who don't get along well together and a lot of things that have to be straightened out. We have for instance, a very fine blood vessel surgeon, Freeman--none better in the country. When a child comes there with patentductus arteriosis he's the one I'm going to have operate. I'm not going to get the chest surgeon because he goes in and takes out a lung just because this phenomenon is in the chest have him do the surgery; but you'd be surprised to find out that he's a little jealous. He wants to know why he didn't get to see that patient and operate on him. I think that this is something for the chief of service and myself, if necessary, to handle and not someone he doesn't like whom I've decided to make coordinator of the program.

GENERAL BLISS: I think our thoughts on that coordination are just about the same. Colonel Winn has the greatest coordination out there among his consultants that you've ever seen, but it happens to be done by the executive officer together with the chiefs of services. It's certainly coordination, which is what we are aiming for, whatever you call the personnel. There is a little more time for some of these other hospital commanders to get up there and talk.

GENERAL QUADE: I agree too that the appointment of a consultant coordinator might be embarrassing to the men and I think the coordination can be done by the chiefs of services and the committee. Each of our chiefs of services is preparing a proposed sketch for the consultants use for the whole year, and I think that will be the answer to the question of coordination. There were several consultants who have been approached on this overseas proposition. They raised the question of pay and mode of travel, and one of them who happens to be a reserve officer also wondered if he could be called to active duty for that period and travel by boat.

GENERAL BLISS: Colonel Cole will answer all of these questions.

GENERAL QUADE: There is a question I'd like to ask you, if the legislation proposed will permit the use of retired officers on the consultant staff?

GENERAL BLISS: Yes

COLONEL DUKE: This policy of appointing chief consultants and coordinators originated when Dr. Bowers' group went on an inspection of teaching hospitsl. They came back and unanimously felt that the consultants' organization had to teach the hospital what to do. They thought that a closer organization would be best and that a coordinator, through which each one of the consultants had access to the commanding officer, should be one of their own group.

At Brooke General Hospital--I think Colonel Streit will bear me out here--he had his group appoint the consultant themselves. It was agreed that that was the best way to organize.

COLONEL RUDOLPH: What is the relationship, if any, of the army area consultant to the teaching consultants of a general hospital within the army area?

COLONEL COLE: I'll try to answer that question first. The recently promulgated policy formerly set up in this office with the consultants belonging to the army surgeon is that they have no connection with the teaching hospitals. Now, if you have a consultant in your area that the teaching hospital wishes, and they contact you, you can lend this man, but as far as sending your consultants out to inspect the general hospitals or to make rounds in them, I believe the policy is that they shall not do that. Teaching consultants will be appointed for these particular hospitals. Teaching hospital consultants will carry on the teaching there and not the consultants in the army area.

There has been considerable discussion, and we have had several staff meetings with General Armstrong, or, at least, I talked to him recently during the absence of General Bliss regarding overseas consultants. This is the condition we are faced with in sending consultants overseas--if we send civilian consultants overseas, they will be paid the usual consultant's fee, plus $7 per diem while traveling without the U. S., in comparison with $6 a day while traveling within the U. S. Many of these consultants have come back and said that they would go over provided they could take their wives or other dependent members of their families with them, and they want to travel by boat. This is the proposition: If we send these people by boat, it means that we have to send them over on a commercial boat with their wives which would require about 12 days. This means that their pay and their transportation will have to be paid on a commercial basis, which would amount to about $300 each way, adding to, roughly, about $600. They get $50 a day while they're on the boat, for about 12 days each way, which makes another $600,

and it runs up to $1,200 to get a man over there and back without doing any work. Now, they are ordered over for approximately 30 days. When we have a man over there for only 14 days to do the work which we require him to do, at $50 a day for the 14 days it runs up to about another $700, so you can see that $1,200 plus $700 makes it approximately $1,900 in figuring the cost when we send the consultant over in this manner. If we can send him by Air Transport Command, and that's the way we are contemplating sending them, they will leave Westover Field, if they're going to Europe, in the evening and arrive at Frankfort, Germany, the next day. This takes one day at $50, and no transportation charge. Then we have the use of that man over there for approximately 28 days, and he comes back on the next day. In order to cover about two general hospitals and about twelve station hospitals, it will require about 28 days. A man can't cover that many hospitals in 14 days. In order to get the work done and to accomplish the mission which we feel we are attempting to do, we think that these consultants should go in this way. It will do two things: first, give us the man's services for a longer period of time, and second, cut down the cost tremendously.

General Bliss, I would like to introduce at this time Dr. Henry L. Thomas, of Baltimore, who is one of the consultants to the Secretary of the Army, and I believe he has a few words that would be of benefit to all of us in regard to this program prior to making the final summary. Dr. Thomas.

COLONEL THOMAS, PROCUREMENT BRANCH, G-1, GENERAL STAFF: General Bliss, it's been a real privilege to be allowed to listen to this conference. When General Bliss invited me, I was very pleased to come, and I realized that he was extending an unusual invitation to a person who hasn't even got a caduceus on, and I feel very strange about that, and I can only say to you that I am still a consultant and I suspect that my rating as a procurement officer will be good or poor. However, I wasn't expected to really procure medical officers in a short period of five weeks, but I suspect that I have fulfilled the mission that General Paul had in mind which was to educate one more civilian doctor, and I have really been educated in these five weeks, and it's been extraordinarily interesting. I have been educated because of the enthusiasm and interest that I've found all through the Army in the present medical program, and that's not only in my travels to several medical installations, but also up in the General Staff. This was, I must say, quite a surprise to me, but I find that it's not a surprise to the officers here in The Surgeon General's Office, where they realize the interest and cooperation that is being given them in their efforts.

I remember the consultant system when it was just getting started. In fact, when I went down to Atlanta, in August of 1942,

if Colonel Winn thinks that they put on their system by a method of trial and error, he should have seen me in August, 1942. There was no blueprint by which to go then, and in listening to Colonel Winn, I suspect that his scheme has been about 99 percent trial and one percent error. I think mine may have been the other way 'round. However, it was a beginning, and it was a very interesting beginning. The thrilling thing now is to see this group of officers of the Medical Corps setting the pattern for the activities of the consultants, and to me that's been the interesting thing that I've gotten this morning. Whereas when we were turned loose at first, we didn't know what to do and the officers under whom we served didn't know what to do. I'm sure that Colonel French had no more idea what I was supposed to do or how I could do it when I reported to him than the man in the moon, and I had not that much, either. However, he was splendid in helping, and we gradually worked out places where we could be useful, and the interesting thing now is to hear the thrilling reports of General Denit, Colonel Winn, and Colonel Cole about the program and to see the way in which the thinking about the future is going. I don't think I can add anything constructive at this time to the discussion of this over-all program. I am vitally interested. I know what a consultant is confronted with. However, I see no conflict between the way the expression of thinking this morning is set up and the activities of the individual consultants. I have derived a somewhat different point of view since this past five weeks, and I'd like to say just one or two words about my differences of thinking now, than five weeks ago. Colonel Winn stressed one point which I don't think anybody else has mentioned and that is that he insists on the Regular Army chiefs of services taking an active professional part in all of the exercises on their services. I think this is of great importance. I can see how a clinician in administrative work, five or six years away from any clinical work, will feel rusty. Those of us who are in different work, and were in tropical medicine when we came back to our old kind of medicine, were rusty. I remember seeing Hugh Morgan shortly after he went back to civilian life and he said he had never studied so hard in his life. I can understand any officer feeling diffident about expressing his opinion on a clinical subject that he has been out of five or six years. However, I think it is of utmost importance, and it will be one of my objectives to explain to the consultants I see from now on to make it a joint effort between the chief of the service and the consultant who happens to be there that day.

General Denit spoke of the cordial relationships and the methods of maintaining them. All of you who know General Denit or who have had the pleasure of serving with him know that that's no trouble to him if he can get at the officer, and apparently he is making it his duty to get at the officer. Well now, I feel that I can go back to the consultant committee and explain to them that

this is part of their duty as well; that they must go all-out in their effort to maintain this cordial relationship which is so beneficial to both.

Colonel Cole said one thing too along this same line and that is that the consultant system as set up now is a gigantic scheme, a very expensive scheme; one involving a great many civilian consultants. My visualization is that year by year more Regular Army officers in medical surgery and psychiatry and in the specialties will be available just as two of General Denit's officers now are serving as consultants. This number will increase year by year and the number of civilian consultants will diminish. That is as it should be. I hope, however, that all of the officers here will try to maintain some close contacts with those of us who are really interested in the Army Medical Corps and its future. And it seems to me that there can always be important relationship and exchange of ideas back and forth. I had no speech prepared when General Bliss said that he was going to ask me to talk, so you will have to forgive me for not making a formal talk. I just want to say that I am going to take back to the meeting of the Consultants' Committee which acts in an advisory capacity to General Bliss as much as I can of what was said this morning.

COLONEL COLE: This will be only a short talk and it will be the final summary of the things that have been brought up this morning and this afternoon. I want to personally thank Dr. Thomas for his observations and for transmitting to you gentlemen the observations he has made relative to this program. In making appointments of civilian consultants, an application is sent in here and the application is cleared and sent through Civilian Personnel to the Secretary of the Army for processing. A letter is written to the initiating facilities stating that these papers have been received and that they are now in process of being sent through. When the appointment finally comes through and is received in our office, another letter is sent out stating that this consultant has been appointed and that his services are now available to the initiating facility. On one or two occasions this morning the question has been brought up about extending the length of service beyond the ninety-day period of certain consultants. This can be done, but the request for this service should be sent in early so that it can be processed through Civilian Personnel; the authority obtained, and then sent back to the initiating facility prior to the time the consultant's time is up, so that you won't be using him in an interval for which you have no authority. Further, you will have difficulty in paying him if you do not have authority to use him. I believe when we look back over this program which has been in vogue now only a year, we can look back on it with a little pride. Personally, I think our consultant program has really turned over well in one year's time. As you know we started out with a new venture. We never had civilian consultants before in such capacity and in such numbers, which was a new departure. It was

something that had been discussed here several times. It had to be worked out with trial and error, and there have been a good many errors and many more trials; but I think the program has come through in excellent shape. And I think when we look back on this program of having been in vogue only one year and read the reports of the consultant committees that went out last fall and evaluated our hospitals, we can't help but see that in one year's time we've accomplished a great deal. I think when you compare our teaching hospitals to hospitals of like capacity, like facilities in civil life, and realize that those hospitals have been carrying on a teaching and training program for many, many years, some of them 50, 60, or more years, we have established a very excellent training program in this period of one year. There have been a few questions brought up from time to time as to whether we shouldn't initiate more research problems into our training program. I think again when we look back at the civilian institutions that were in vogue only one year that we'll find that our research program would compare very well and perhaps surpass many of them that have been in operation only that long. We are, however, establishing these programs and these facilities in our teaching hospitals under the direction of our consultants. As I stated in the beginning of my talk this morning, the consultant program and the training and education program must of necessity work hand in hand. They are inseparable. You can't take out the training program and run that in one line and run your consultant program in another. They are both hooked up very intimately and closely together, and, as such, there must be extremely close coordination in this office between those two departments or divisions. I'm happy to say that that exists. I want to take this final opportunity to thank all of those who participated in this program today, because I think it has required a great deal of work on everyone's part, and it has covered a great deal of territory and embodies and entails a great deal of detail in order to get this thing up. We hope that we have presented this consultant program in such a way that you gentlemen will have a better understanding of what our consultant program is and what we are attempting to do than you have ever had before. And we want to extend to you an invitation that if there is ever any time that we can help you, we are at your service, and if we don't know the answers we will do everything in our power to get the answers for you.

GENERAL BLISS: I hope that there might be some discussion from some of the hospital commanders here. I hope that you will think of these things in the consultant program in your hospitals. First of all that you have a staff of medical officers in your hospital; a staff that consists of full time men and part time men, but it's all the same staff. And secondly, do not think that the consultants are apart from us; that they are primarily coming to help us. They are of us and we are of them. We are all together in this work in attempting to raise to the highest possible level the standards of care and treatment in our hospitals.

I hope there will be some others here who will discuss this in the next few minutes. Just stand up, introduce yourself, and talk.

COLONEL STREIT: I enjoyed Colonel Winn's paper this morning very much. It is to be congratulated. Colonel Winn had the unique opportunity of having two fine medical schools in San Francisco from which to draw his help. At Brooke in San Antonio, the problem has been somewhat different in that we have no medical school at all. And in some specialities perhaps a lacking in the professional talent to assist us in carrying out our program. For that reason we have called on numerous members of the faculty of the University of Texas at Galveston, members of the faculty at Bailey University Medical School at Houston, and some members from the Southwestern Medical College in Dallas to assist us. In other words the consultants of the attending staff at Brooke came from five or six cities some of them 200 or more miles away from San Antonio. It occurred to me that it was important to have these various attending staff members meet one another and get acquainted. For that reason, about last October we had a dinner to which these consultants were invited at which time all aspects of the consultant program as we knew it then were presented, the different hospitals in which the program was in session, the number of residents we had in those hospitals, the number of consultants The Surgeon General had; in other words all aspects of the program were presented to them. At that time I asked the visiting staff members to kindly organize a unit. An organization to be known as the Consultant Group of Brooke General Hospital. I suggested that this meeting be held without the attendance of Army personnel. I further suggested that they have a free discussion, criticize our program, give us constructive suggestions on how to improve it, and give me suggestions for new additional members to the consultant staff and suggest chiefs of the various specialities to act as the heads in that department. This meeting has been held and I have a report of that meeting which was presented to me by the acting chief of the organization. In this way, although we lack a medical school that would naturally draw the group together, we feel that we have, or are accomplishing, the coordination which General Bliss so much desires and which is so necessary. The members of the consulting or visiting staff at Brooke show an unusual degree of enthusiasm in their teaching. They have inspired the residents in a similar manner, and I feel that the morale of the teaching program there is superior. There is one thing that Colonel Winn said that I would like to comment on. That was when he stressed the importance of having the chiefs of services and the hospital commander assume the final responsibility for the way the program is carried out. I feel that there should be no question about that in any case, and I personally hold each chief of service responsible to me, in the final analysis, for what is accomplished on that service. The coordination of the program is in the hands of the chief

of the surgical service at Brooke. I would very much like to turn it over to an officer who would have that sole duty, because it involves many administrative and technical procedures and requires considerable time; but there does not appear to be one available at present. And Colonel Seelly is doing a very splendid job of carrying this program out. Personally I feel that is preferable to having a civilian specialist do this, particularly where there are many different schools of thought represented and possibly from different medical schools and different centers and cities. However, the program must be coordinated and must be coordinated in detail by someone if it is to succeed. I again wish to compliment Colonel Winn for the splendid and very instructive way in which he presented the program this morning.

COLONEL KEELER: Colonel Winn, I believe, has left nothing that needs to be said on this subject, and I certainly would not attempt to change anything which he has set forth. I would like however to go on record as being very much in favor as Colonel Streit has stated that I do believe that the chief of the service under the commanding officer is the person who should be responsible for the coordination of the program. I just have one other observation that I would like to bring out. It might be of interest. Certainly in my area, when this consultant program first became operative, it was very difficult for us to get consultants. I paid repeated visits to the men we wanted, and it took quite a selling job to get these men to agree to come on with us as consultants. At the present time we are having more requests from men to serve as consultants than we can possibly use.

COLONEL STANLEY: I have a situation that's unique. Each head of each department sponsoring a residency at Oliver is a Regular Army officer, and an American Board man in his right but we are in a position of having no quarters. Many of my men whether they are lieutenants or colonels are living in houses once occupied by the colored servants of citizens of the town. Now when Colonel Thomas of G-1 spoke of the possibility and the intent of Regular Army officers becoming qualified and carrying on the key positions in this registered post. I have told the men a couple times but I have no assurance that I will have them individually three months from now and I would like to request the assurance that I may go back to these young men and say you will remain on this job two years or longer so that that young man can make a contract, can buy a house or can dig a hole in the ground and have some insurance to his family.

COLONEL HARDAWAY: I just want to heartily concur in Colonel Winn's remarks. I also want to concur in the remarks of Colonel Thomas. The work of the consultants has certainly been very meritorious, and as the time goes by I think the Regular Army officers are going to have to assume that responsibility for the Corps, and I

think Colonel Thomas' suggestion is certainly 100 percent correct.

COLONEL RICE: I am in one of those positions where I do not have a general hospital but I do have about thirteen station hospitals scattered over some six or seven states. I would like to hear some discussion on how that can be coordinated a little better. I can readily see how you can coordinate in general hospitals, but when you have so many different types of hospitals, in sizes, and they are over such a broad area perhaps a discussion on that subject would help us.

GENERAL BLISS: If we don't get any discussion now on that point, George, drop around Saturday morning--I have a few things in mind.

COLONEL WINN: I'm sorry I had to hurry through as I did. There are a couple of points that I would like to stress which I have already mentioned, and one of them is the apparent duplication, perhaps, of consultants on a given specialty or sub-specialty. I have taken pains to inquire into this at Letterman, and when I go to the staff officers, the interns, and residents and ask them about it, I say, "I notice you have two men here on neurosurgery, and you haven't got very many patients. Why do you need two?" And they are very firmly convinced that they need two. They supplement each other in their attitudes. One of them is a man who is very conservative, the other one is a man very well trained in physiology of neurosurgery, and they wouldn't give up either one of them. The same thing is true on several other sections, and so I don't think that we should let that point bother us. The other point that I wanted to mention was that in no case have I ever heard one of my consultants mention the money he receives. They are not too much interested in it. We have men on the obstetrical service who prefer to come over every two weeks rather than once a week, because they think they can get a better job that way. They know they can get $50 for each trip if he wanted to come that way. When I spoke of possibilities of the education committee, in reviewing the program, certainly I know we haven't done as good a job as we should have. And I also spoke of the chiefs of services rotating consultants in their work. We have the consultant, for instance, who is confining his ward rounds to officer patients in surgery. He tells me that he doesn't get as much out of this consultant job at Letterman as he gets out at Ft. Miley, the Veterans' hospital. Of course there isn't much of a variety there and he would like to do a little more for us; but he finds he just can't and I think that he should alternate this. Another man is making rounds on enlisted service. But the fact that he hasn't been doing any more than he is doing now is just as difficult in my opinion as anybody else's. If he isn't interested in going then he gives it up. Another instance is the case of Dr. Guy Vogel, one of the best internal medical men

in the country. He isn't used on ward rounds at all; he is used in the clinics, but he should be rotated on this other work too. These things are, as far as I am concerned, discovered accidentally, and I think we should have discovered them sooner although the committee has been doing more work in the direction of hospital duties.

COLONEL REYER: When I hear these commanding officers talk about having one to two to five medical schools in their vicinity I kind of envy them for as you know I'm stationed in the southwest corner of Texas on the desert there where we have all of the qualified men in El Paso, eleven in number, on our staff. As a result of not being near a school, we have lost our resident; but we are continuing our training program for those who are still there and are very enthusiastic about it. These doctors that we have from town, as Colonel Winn has said, are not interested in the money. They are not interested in the hours. They do report to us when they come, they eat with us, meet with out educational committee, and tell me "Anytime you need me day or night, don't worry about paying me; but call me!" They are very interested.

COLONEL LEHMAN: I merely got up to make it a matter of record that we use the consultants at the Army and Navy General Hospital in full accord with the program, and that we all benefit from it and from these talks today. I agree with the expressed opinion here that we can do a great deal with our relationships with these consultants, and we go out of our way to make them feel that we are glad to have them there and so they appreciate it. I think the results from that may be shown later in our procurement program.

GENERAL BLISS: Thank you very much gentlemen for the extra discussion. Of course we want to have our regular medical officers in charge. Of course we want them to qualify; that's our whole thought in the rehabilitation program of the Medical Department. We want to have our men qualified and recognized as they will be by civilian medicine.

F. Special Problems NP Consultants . . . . . .Col. John M. Caldwell Jr.

Now then, we will talk a few minutes about what has been referred to as the "Minnesota experiment." There has been distributed before you a little brown pamphlet, "Psychotherapy and General Medicine." There is a tendency on the part of physicians, when they encounter a mental or a personality problem to refer that to the psychiatrist. We feel that all officers should have some acquaintance with the handling of personality problems and psychoneuroses, and it is with this in mind that we are proposing to have during the coming summer, in each Army area, a series of days devoted to the teaching of psychotherapy, interviewing techniques, and the patient-physician relationship. The "Minnesota experiment" to which I have just referred was put on in Minneapolis last summer by a group of psychiatrists under auspices of the University of Minnesota, and to this meeting, which lasted for two weeks, there came from all over the state of Minnesota, men who were in practice and had been so for a number of years. They were internists, they were general practitioners, I think there was a surgeon or so in the group, pediatricians, dermatologists, and so on. During this two-week period they received intensive indoctrination into psychiatric concepts, the patient-physician relationship, techniques of interviewing, and incidental psychotherapy that was given during those periods. At the conclusion of that time, it was unanimous that this period of instruction had been of tremendous benefit to each man, and he felt he could go back and treat his patients, whatever they might have, much better than he had before. The patients that were used in this demonstration were chosen from the outpatient clinic at Minnesota as they came, whether they had heart disease, kidney disease, a psychoneurosis, arthritis, asthma, and so on. Some of them had been under treatment for twenty years, and it was demonstrated that by the use of psychiatric techniques a great improvement could be brought about in patients who were largely brushed aside and disregarded. We have thought of trying to put on some teaching program for all officers in the Army on basic concepts in psychiatry and we in the Army are unable to do so. We do not have the available personnel. No civilian university at the present time will put on such a program, but it has been agreed by Dr. Kennie of New York that teams would be formed of civilian consultants who would go, one into each Army area this summer, and put on a two weeks' demonstration course. To that course we propose to send perhaps five men from the general hospital—the host general hospital—and twenty others to be selected from the Army area. Those men will be selected by the Army surgeons from smaller station hospitals, dispensaries, disciplinary barracks, the training center, or wherever you might choose to select them. The definite time and place and the number of officers to be selected for this program will be announced at a later date, and in order to give you an idea of what we are trying to accomplish, this pamphlet has been distributed.

I want to call attention to something that you all ready know—that we have remaining in the Army very few officers who are qualified

in psychiatry. That condition will grow worse in the next year to two years, until we can get some of our people out of residency training. In the Army areas particularly, we will have to depend on our civilian consultants to solve most of your problems, whether it be in the station hospital, the training center, disciplinary barracks, or at the induction stations. I'd like to refer, too, to the residency training program. In psychiatry we have to confine residency training to three general hospitals. That has been done, not because of a deficiency in any of the other hospitals, but because it was required that we have not less than three board men qualified as instructors as a permanently assigned staff in any teaching program that we would put in. A minimum of three, and preferably five. The hospitals were chosen because of their proximity to medical centers and as soon as possible a residency program will be extended to other general hospitals when we have qualified teachers within the Regular Army who can carry it on. Here, in the office, we have added two additional members to the neuropsychiatric staff, I think since we met a year ago, one representative in psychiatric social work, Major Elwood Carp, and one representative in clinical psychology, Lieutenant Colonel C. B. Gerseni, both of them having had extensive Army experience during World War II. We feel that no psychiatric program is complete without the inclusion of psychiatric social work and clinical psychology personnel. In line with the developing of such specialists which we do not have available within the Army, except for one or two instances, there has been published in the Department of the Army Circular No. 3, as of the fifth of January, an announcement of civilian training to Medical Service Corps personnel in civilian universities, to a master's or a doctorate degree, in either clinical psychiatry or psychiatric social work. Other than that, I don't have anything of importance to bring up at this time.

G. ADMINISTRATIVE PROBLEMS IN CONSULTANT PROGRAM. . . . . Mr. Elroy W. LaCross

When the procedures for the appointment and pay of the civilian consultants were initiated, our aim was to minimize as much as possible the red tape required, and that which was required was prescribed by law and not by regulations initiated by lower echelons. Congress has prescribed by law certain things for us to do in hiring employees in the Government service--and whether we consider them sound is beside the point. We have had to require a certain amount of red tape which we would like to reduce, and when the opportunity arises we will reduce red tape just as much as possible. I am glad to report that the procedures that were worked out have developed now to a point that we have no major administrative problems with the Armies, the general hospitals, or the air service in getting our consultants appointed and paid. Perhaps you can tell me of some of your experiences that have not come to our attention. There are a few things that can be done, perhaps to alleviate some of the minor difficulties that you are having.

We have had three questions asked and I'd like to answer those now, and also give you a few suggestions that may help in making your relations with the consultants a little more pleasant, not that they have indicated that they are not, but anything that we can do to be of better service to them and to you is our aim. You have been using the consultants considerably more this year than any previous year. Their excepted appointments are for ninety work days. Some instances may occur where you want to use these consultants for more than the appointed period. Their ninety day appointment can be extended, but not to exceed one hundred and eighty days in any one fiscal year, and where it is necessary or desirable to use a consultant for longer than his initial appointment, a request to this office, prior to his use, will make his services available to you for a longer period. Please do not make the mistake of working him in excess of the ninety days and then ask for prior approval retroactively. This cannot be given. A little planning will make these men available to you for additional time.

There is no curtailment of their services contemplated due to a lack of funds during the current fiscal year, nor is there a curtailment anticipated in the future.

For the Army and the station hospital consultant, if the surgeon of the Army will see that the certificate of services rendered accompanies the travel voucher for the consultant, if there is to be a claim for travel reimbursement, it will speed up the settlement of their claim. We are experiencing some instances where they arrive separately. Whenever you separate two documents that are necessary for one action, an unnecessary delay is occasioned.

Some of your consultants travel a short distance. This is true of both the Army and the general hospital consultant. He makes frequent trips, but each amounts to very little as far as reimbursement is con-

cerned. It has been your practice to submit one certification each month for services rendered, but you have been submitting an individual travel reimbursement voucher, for each of these little trips, when it amounts to maybe a dollar or two. In those instances, you can save yourself, the consultants, and all concerned who handle these vouchers if you will likewise consolidate these vouchers for reimbursement for travel.

There has been in one of the Army areas a close reading of the regulations governing travel, and payment for travel by privately-owned automobile on a mileage basis has been denied. This matter came to our attention yesterday, and, on bringing the particular case to the office of the Chief of Finance, they could not disagree with the local finance officer, so I carried it further, to the Office of the Secretary of the Army, who wrote the regulation. They agreed that it was the wrong interpretation of the regulation. At least, it wasn't their intent to limit the travel of consultants to prevent travel in their own automobiles on a mileage basis. As a result, they told me yesterday afternoon that I could pass the word on to you that travel by privately-owned automobile as limited by Civilian Regulation 155.2-5b was being amended retroactively to September 1946 to comply with Public Law 644, which authorizes travel on a mileage basis. So if you are experiencing difficulty with any other fiscal office in processing reimbursement for travel by privately-owned automobile by a consultant on a mileage basis, just hold it for a while, and an authorization will be published by the Secretary of the Army to authorize payment on a mileage basis.

Colonel Cole this morning mentioned the practice of reappointment at the end of each fiscal year. I just want to add a little bit to that. Last year, when we asked who should be reappointed and who were not to be reappointed, these lists got into this office, I fear, without the commanding officer personally seeing what was included and who was to be eliminated. In a few instances, errors were made because of that oversight, so I would like to recommend that when these lists requesting reappointment or nonreappointment leave your command near the end of this fiscal year, you personally review them so that we will not embarrass you, The Surgeon General, or the consultant.

If there are any administrative problems that you have that we do not know about, and you think we can help you with, we will be only too happy to discuss it further either here or with you individually as you get an opportunity to come by the personnel office.

H. ATOMIC ENERGY.....Colonel James P. Cooney

General Bliss, hospital commanders, Army surgeons, visitors, it is a great honor and pleasure to be here this afternoon. I appreciate the opportunity.

I thought it might be of interest to you to know what we have done thus far, in so far as atomic energy and atomic warfare are concerned, and what we anticipate doing in the future. During the war, no Regular Army Medical Corps officers were assigned to the Manhattan Engineering District. The medical staff was composed entirely of Reserve officers. Therefore, after the war and Operation Crossroads (Bikini), our good friends, who, incidentally, did a very excellent job, returned to their civilian duties and the Regular Army was called upon to take over. My first assignment was at Bikini, where I was liaison officer for the Office of The Surgeon General. From there I was sent to Hiroshima and Nagasaki for a brief study of the casualties one year following the detonation. I returned to Washington and was assigned to the Manhattan Engineering District. My first duty was to visit the plants throughout the country and ask questions. Individuals working in the plants were so security conscious that it was extremely difficult to find out much concerning the medical problems on my first visit. However, after becoming better acquainted, I found everyone most helpful and anxious to advise me as to the medical problems.

It appeared that the best solution toward becoming acquainted with the many and varied problems was to start an on-the-job training program. The Armed Forces Special Weapons Project under General Groves and the Atomic Energy Commission were both very cooperative. They gave us everything that we asked for. We were able to place one Regular Army officer at Dayton, Ohio; one at Hanford, Washington; four at Los Alamos, New Mexico, as well as three ASTP's at Los Alamos, and one at Oak Ridge, Tennessee; one at the University of California for training as a radiochemist; and three are now stationed with the Armed Forces Special Weapons Project and one with The Surgeon General.

We organized a five-day indoctrination course to be given to members of the Army, Navy, Public Health Service, Veterans Administration, and Air Force. We started this course in May 1947, and hope to continue it until such time as every doctor in the above-mentioned services has been able to attend. Beginning in December, 1947, we invited the deans of the seventy-two class A medical schools in the United States to send a representative from their teaching staff to attend this course. As of the February course we anticipate having from sixty to sixty-five representatives from the above-mentioned medical schools. The course is very elementary, and its purpose is to give the average doctor some idea of the problems that will confront him in case of war when an atomic casualty is admitted to the

hospital for treatment. Our instructors serve on a voluntary basis and are furnished by the Army, Navy, Veterans Administration, and U.S. Public Health Service.

In addition to the above short course, the Armed Forces Special Weapons Project made possible our arranging with the University of Chicago to give a six months' course to prepare National Defense officers for training which will enable them to advise higher echelon commanders in time of war. We anticipate expanding this course to nine months next year and also have a similar course at the University of Rochester, New York. At the termination of the 9-month academic training, these men will have three months on-the-job training at Los Alamos, Hanford, and Oak Ridge. Thus far we have not decided how much training will be necessary in order to acquaint a medical officer with all the problems with which he will be faced, but personally, I would like to have fifty officers receive high level training during the next two years. Unfortunately, this seems to be impossible as we do not have the personnel nor the facilities to care for them. I believe that on-the-job training at such places as Los Alamos and Sandia will be far more valuable than a straight academic course in some university. However, we will probably have to have a combination of the two in order to get the complete realization of all the problems concerned.

What are some of the problems that will face the medical officer in time of war? He must be acquainted with the hazards of radiation and the methods for detection of such; the problems of instrumentation; developing and handling of film badges; diagnosis and treatment of radiation casualties; and laboratory techniques associated with determination of the excretion of radioactive elements deposited in the body. At the time of the detonation of the bomb, some thirty radioactive elements are liberated as a result of fission. In addition to these being a hazard externally, they may be absorbed into the body by inhalation, ingestion, or through an abrasion in the skin. A great number of these elements are bone seekers and become deposited in the bones. They remain there a long time, depending upon their half-life, and thus may cause problems similar to the radium dial workers who ingested radium by tipping their brushes in their mouths and later died of osteogenic-sarcoma as a result of the radium deposited in their bones. It will be necessary to examine all patients who have been injured by an atomic bomb to determine whether or not radioactive elements are deposited in their body. This will be necessary before such individuals will be able to obtain life insurance.

At the present time we are training two medical officers and six noncommissioned officers at Los Alamos, New Mexico for the purpose of establishing a school for enlisted personnel at Brooke Army Medical Center. This school will cover the problems of radiation detection,

instrumentation, handling of contaminated casualties and developing of film badges, and laboratory procedures connected with excretions of radioactive materials. It will be given to the medical, surgical, X-ray, and laboratory technicians.

As to the problems of radioisotopes, I know that you are all anxious to have an isotope program established at your hospital. However, I ask you to be patient, as we will have to wait until we have a sufficient number of people trained in the hazards of handling radioactive materials before such programs can be established. The handling of radioactive materials is a hazardous procedure. You all had friends who were injured in the early days by injudicious use of X-ray. Those men were martyrs to science. We must profit by their sad experience, otherwise their sacrifice will have been in vain. At present we are using isotopes at Letterman General Hospital with the help of the trained personnel at the University of California. As of October 1948, we hope to establish an isotope program at the Army Medical Center, Washington, D.C. If in the future it becomes necessary to have isotopes in all general hospitals, we will do so, but we are going to proceed cautiously.

I. PHYSICAL MEDICINE.....Lt. Col. Benjamin A. Strickland, Jr.

First of all I would like to express the keen appreciation of everyone who is engaged in physical medicine, both in civilian and military circles, for the splendid support which all of you have given this new specialty. Because of the efforts of General Kirk, the Army was the first of the governmental medical services to establish physical medicine as a separate and distinct specialty. As established by W. D. Circular 349, dated 28 November 1946, the physical medicine service in Army general hospitals consists of physical therapy, occupational therapy and physical reconditioning. The newness of the physical medicine service has led to some lack of understanding as to its exact purpose and manner of function.

In Army hospitals there are certain services that literally "serve" all the other services engaged in actual care and treatment of patients. These three are the laboratory, x-ray, and the physical medicine services. Just as the laboratory service is called on to serve every patient in the hospital, for the purpose of laboratory testing and diagnostic procedures, the x-ray service functions as an adjunct for diagnosis and treatment, when roentgenograms are required or x-ray therapy or radium therapy is necessary; in like manner does the physical medicine service provide definitive therapeutic treatment, certain diagnostic assistance, and dynamic convalescent care whenever requested by the surgeon, the internist, the neuropsychiatrist, etc. These three adjunct services can be said figuratively to "cut across" all the other services and sections in a general hospital that are engaged in patient care and treatment in that their work comes from all the other clinical branches, the services engaged in the treatment of patients.

Thirty years ago, the specialty of orthopedic surgery was experiencing severe growing pains. Some general surgeons felt that orthopedic surgery was their responsibility per se, and could see no use for the development of orthopedics as a distinct specialty. Twenty years ago, anesthesiology was just beginning to attract doctors of medicine as a specialty. Many surgeons still felt that the nurse-anesthetist was all that was really necessary. But now, the best informed operating surgeons insist on a trained anesthesiologist who is an MD.

Physical medicine has advanced tremendously during the past ten years, but still finds itself in a situation somewhat reminiscent of the development of both orthopedic surgery and anesthesiology. Many orthopedic surgeons still feel that there is little to physical medicine beyond heat and massage, and that they can get along perfectly well without a doctor trained in physical medicine being interposed between himself and the

physical therapist. They forget that only three decades ago many general surgeons regarded them as interlopers, when they set themselves up as being particularly qualified in bone and joint surgery. It is of unique note that it was a well-known orthopedic surgeon, namely, Doctor Frank Ober, professor of clinical orthopedics at Harvard Medical School who in 1943 stated: "The first World War established orthopedic surgery as a specialty of medical practice and I believe that this war will do the same thing for the field of physical medicine". That the physican trained in physical medicine is now firmly established and has a real service to offer his colleagues is attested to by the establishment during 1947 of the American Board of Physical Medicine. This new specialty board has the considered approval of the Council on Medical Education and hospitals of the American Medical Association, of the Advisory Board of Medical Specialties, of the American College of Surgeons, and of the American College of Physicians.

Now, what is the present status of physical medicine in Army general hospitals? A physical medicine service is at present functioning in the thirteen named general hospitals and this service is headed by trained medical officers. Sixteen Regular Army medical corps officers, all of whom requested assignment in physical medicine, are engaged in this specialty. Contrast this, if you will, with the number assigned to physical medicine on 1 September 1946, which was a dismal two. Likewise the number of A. U. S. officers assigned to physical medicine has increased from 13 to 38. The question probably arises in your minds as to what professional training these medical officers had had. Thirteen of the Regular Army medical officers have received six months' post-graduate courses in civilian institutions, and three are now assigned to approved residencies in physical medicine.

In October 1947, out of the 550 A. S. T. P. medical corps officers who comprised the October increment at the I. F. S. S. 26 of these young doctors requested training and assignment in physical medicine, all voluntarily. Three months' courses are being given these 26 young A. S. T. P. medical officers at five general hospitals. Upon completion of this three months' on-the-job course, these medical officers will be classified in the MOS 3180D, which is Medical Officer, Physical Medicine and assigned as requisitioned to assist the Regular Army medical officers who are chiefs of physical medicine service.

I would like to say a few words about physical reconditioning. Most physicians and surgeons are so completely absorbed and preoccupied in getting their patients over the acute stage of their illness or injury, that oftentimes they

lose sight of the importance of the period of convalescence. During the recent war several controlled studies were conducted on the problem of convalescent management. One of these comprised several hundred cases of virus pneumonia, which were divided into two equal groups for the purpose of this study. One group was given an active program of physical reconditioning. The other group, under the same condition, identical type of management, etc., was given no convalescent exercises but allowed to engage in normal activity during convalescence. Of the former group, that is the group treated with physical reconditioning, only 3 percent had complications or recurrences of their disease. Of the group that did not receive physical reconditioning, 30 percent had complications or recurrence. Furthermore, the average hospital stay of the group that did not receive physical reconditioning was forty-five days. The average length of the hospital stay of the group that did receive physical reconditioning was thirty-one days. Other studies of similar significance have been reported. It would appear that in peacetime Medical Department activities, a more extensive use and exploration of the possibility of physical reconditioning are indicated.

The utilization of certain therapeutic procedures in the realm of physical medicine are worthy of discussion. One of these is fever therapy. Fever therapy has been authorized for use at ten of the named general hospitals. Medical officers trained in this technique are assigned to physical medicine at these hospitals. Therapeutic fever by means of a Kettering hypertherm type of fever cabinet has certain advantages over fever induced by inoculation with malaria, or injection of typhoid vaccine or sterile milk. The most important of these is that the fever can be controlled perfectly at all times. It is induced from outside to within or produced externally, and complete control is possible at all times. The days are gone when fever therapy was used at temperatures of 106 and above. As most of you will remember, this was the technique used in the treatment of sulfa-resistent gonorrhea. This technique is about as outmoded today as blood-letting. Fever therapy has been found to be extremely useful in certain opthalmological conditions. Thousands of treatments have been done at the Valley Forge General Hospital mainly in cases of iritis, iridocyclitis, keratitis, and other opthalmological conditions. Extremely remarkable results have been obtained. The patients prefer it to injection of typhoid vaccine or to injection of sterile milk. Another utilization of fever therapy is in certain cases of neurosyphilis. It is borne in mind, of course, that many neuropsychiatrists still prefer, when treating neurosyphilis, to use malaria. But recent studies, a notable one of which was made by Sexton of McGill

University Medical School in Canada, indicate that properly combined chemotherapy with mechanically-induced fever gave a high percentage of remissions and cures in neurosyphilis than malaria. Certain types of arthritis also are quite amenable to fever therapy. The Mayo Clinic and certain other leading civilian institutions are utilizing this treatment in certain types of panarthritis at the present time.

A greater utilization of occupational therapy is in obvious need. Probably the specialist who is most cognizant of this is the neuropsychiatrist. But more and more the orthopedic surgeon is becoming fully aware of the possibilities that occupational therapy has to offer in contributing to functional restoration, to motivation, and to stimulation of recovery.

These mimeographed sheets which have been passed around list certain suggestions regarding improving the therapeutic effectiveness of the physical medicine service in Army hospitals. It is hoped that you will see fit to give them a trial and when you do, the Physical Medicine Consultant's Division in this office will be extremely grateful for your reactions.

Suggestions for increasing the therapeutic effectiveness of the Physical Medicine Service:

1. Adequate number of medical officers assigned to the Physical Medicine Service. Minimum needs have been determined to be:
   2 Medical Officers in General Hospitals of 500 beds
   3 Medical Officers in General Hospitals of 1000 beds
   4 Medical Officers in General Hospitals of 2000 beds

2. Medical officers assigned to the Physical Medicine Service should not be given so many additional duties of an administrative nature that they do not have sufficient time to carry out essential examinations, prescriptions and consultations on all patients referred to and being treated by the Physical Medicine Service. All three sections of the Physical Medicine Service, in order to have therapeutic value, require the active and close supervision of a medical officer with special training.

3. A continuing orientation program of the entire hospital staff concerning Physical Reconditioning. (See TM 8-292).

4. Individualization of the Physical Reconditioning program for bed patients. Rather than conducting a program of calisthenics on the wards, Physical Reconditioning instructors

should spend 20 minutes daily with each individual bed patient in whom Physical Reconditioning is indicated.

5. Fullest possible utilization in actual Physical Reconditioning of patients of all personnel trained in Physical Reconditioning and holding a primary MOS in Physical Reconditioning. (At some installations, skilled Physical Reconditioning personnel are being used only 60 percent of their time in Physical Reconditioning.)

6. A continuing orientation program aimed at familiarizing ward officers with the value of Physical Therapy in definitive medical care, with equal emphasis on the limitations of its applicability.

7. Close cooperation between the Physical Medicine Service and the Convalescent Services Section with the common goal of a dynamic regimen for all patients during convalescence.

8. The extension of Occupational Therapy to all patients who will be benefited by it. Many general hospital patients, because of a lackadaisical attitude of the ward officer toward Occupational Therapy, are retarded in their convalescence by this unawareness on the part of their doctor to the functional restoration, motivation and stimulation available through medically prescribed and supervised Occupational Therapy regimens.

9. An indoctrination of all medical officers that the Physical Medicine Service is set up to provide a professional type of medical care and treatment, particularly applicable during the usually protracted period of convalescence; that its coordinated and integrated utilization has real therapeutic value; and that it has much more to it than simply "keeping the patient busy".

J. MODERNIZATION OF EQUIPMENT.....Colonel Silas B. Hays
.....Colonel Clifford V. Morgan

I will discuss very briefly the program that is underway on modernization of hospitals. The Surgeon General feels that Army and Air Force hospitals should be as well, if not better, equipped than comparable civilian, Navy, and Veterans' Administration hospitals. Working with General Grow, he has appointed a committee to survey all medical installations of the Army and Air Forces in the United States to determine what modernization equipment is required. This survey will probably take all of the calendar year of 1948. It will give us information with which we can go to the Bureau of the Budget and to Congress and request money for future years. We find ourselves now in the position in this office of not knowing the exact condition of equipment in the various hospitals. This survey team is comprised of Army and Air Force members. Colonel Morgan, Deputy Post Commander of the Army Medical Center, whom most of you know, is the chairman and Colonel William Lawton from the Air Force is the vice-chairman. All medical installations will be surveyed. Last year we could not get personnel to do this work and as a result, we sent out two men who did some superficial work in general hospitals only. Following that, we spent approximately a million dollars for equipment. I feel that our money was not as well spent as it could have been had we been able to go at the thing with better qualified personnel and in a more systematic manner as we have this year. Colonel Morgan will tell you of the work that his committee will do.

COLONEL MORGAN: Colonel Hays has outlined for you the mission in the program. I want to say that the committee has already been organized consisting of about eight members and we've laid the ground work and the educational surveys during the past two months. We are now ready to start on the program of covering about 210 medical installations in the Zone of the Interior. The committee consists of one representative from supply, two nurses, an engineer who has experience in teaching repair of utilities at Ft. Belvoir, and three officers from the Air Surgeon's office. We are trying to cover the south in the next two months and the whole United States, I believe, possibly within eight months. I think we can cut the time of one year a little short. There are two things I would like to request the hospital commanders to be prepared for. One is to know what they want when the team gets there. Also I feel that they should have the inventories and their stock record cards on medical supplies available. It would be well if they had available the memorandum receipts to some of the clinics, operating rooms, and the central supply. So as the team goes through, they won't waste a lot of time doing an inventory job. Then if any requisitions are prepared, they should be available to the team. The report of the team will be routed through the

station commander in order that he may recommend changes, if desired, either deletions, additions or changes in priorities. The reports will also be routed through the Army Surgeon, or the Air Command, or in the case of Class II installations sent directly to The Surgeon General's Office. One copy will be furnished for the files of the station surveyed. Now the second important point, I believe, is to have the post engineer available when the team comes. We anticipate considerable difficulty in getting installation made on equipment. Some things like x-rays may need lead-lined rooms, or sterilizing equipment may need walls knocked out, or other modifications may be in order. We have found in a few surveys already made that we have been able to gain the cooperative spirit of the post engineer by having him present. I think it will help build up your relations with him if that can be accomplished.

K. RESIDENCY TRAINING PROGRAM. . . . . Colonel Raymond E. Duke

I'm not going to confine my remarks to the residency training program as outlined on the agenda, but rather I'm going to cover briefly the over-all training activities of The Surgeon General's Office, because you are all more or less concerned with all of our training activities. In formulating plans for training of our medical officers, obviously the first thing we should have is a very clear conception of what we're trying to accomplish. The Medical Department, I believe, has two missions to accomplish in the training of medical officers.

Our first mission, I believe, is to be prepared for mobilization and war. Surely our mission as part of the Army cannot be different from that of the Army itself. The large number of civilian doctors who come into the Army during wartime, with some exceptions, are neither interested in nor trained for the purely military aspects of the medical service. The regular corps, must always furnish the bulk of leadership in this field. So I feel that the great majority of our regular medical corps officers, regardless of what they do in peacetime, regardless of how much professional work or professional achievement, they must receive sufficient tactical, administrative, and staff training so that if necessary, during wartime, they may be capable staff officers, medical planners, and commanders of Medical Department units.

Now our second mission, and surely this second mission is very close to the first one, is that we should be able to provide the highest standard of medical care for a peacetime Army and dependents. There must be developed and maintained in the regular corps an adequate number of officers who are professionally qualified to accomplish this second mission. I think that each individual must be afforded the opportunity to reach the highest level of professional attainment for which he is physically or mentally capable.

In formulating a plan to meet these two missions, we must first know our numerical requirements. How many officers do we need, how many officers do we need in the various categories, and how many do we have on hand at the present time. I'd like just briefly to review these requirements with you because our whole training plan is based on them. May I have the first slide please. Now our Personnel Division and our Resources and Analysis Division tells us that this is the number of officers that we will need in a peacetime Army. The Department right now says that our peacetime Army is going to be 875,000. That of course is subject to congressional action but at least we'll have to have a planning figure. If we have an army of 875,000, we're going to need a total of 16,771 officers in the Medical Department, and 4,771 of these must be Medical Corps officers or doctors; 1,833 must be Dental Corps, 500 Veterinary Corps, 2,706 Medical Service Corps, 5,912 Army Nurse Corps, the Dietitians 331, Physical Therapists 283, and Occupational Therapists 233. The figure I want you to remember right now is that we will have to have 4,771 doctors.

At the present time, as you know, we have authority for 3,000 doctors in the Regular Army. They expect us to make up the other 1,771 by reserve officers on active duty. Now about the 4,771 medical officers; how must they be utilized? Next slide. Our Resources and Analysis Division says that of the 4,771 doctors, one out of ten or 441 will have to fill administrative staff and command positions. One out of ten in a peacetime Army. 149 on staff jobs, and 292 in command jobs makes up the 441. Of the 4,771 we must have 1,749 for general duty--general duty or general practice officers. Of the 4,771 we must have 2,581 or over one-half as experts. Now by experts, I mean men with some degree of professional specialization. Now how about these professional experts. In which specialties must they be qualified? This next slide will show you that of the 2,581 our Personnel Division says that we must have 709 A and B men--that's professional classification. In other words we must have 709 who have the qualifications equivalent to certification by American Specialty Boards. We must have 1,122 C men, men who have had at least two years of training in a specialty; and 750 D men, men with one year of training. Of those totals, 2,581, 761 must be in surgery, 780 in medicine, 263 in neuropsychiatry, and so on. And that gives you a general picture of how these 2,581 experts must be utilized in the peacetime Army. The figure that I would like you to remember is 709, a total of 709 in the Regular Army in a peacetime Army who must have the qualifications equivalent to board certification. All right now, what do we have on hand at the present time? We have 28 in the medical specialties, 25 in the surgical specialties, 48 in other specialties, or a total of 101. In other words, generally speaking, it's true to say that we have about one-seventh the number that we need. We are almost in the same position, professionally in the C and D classification. Now that's the status of our regular corps at this time to accomplish that second mission which I mentioned--that of providing the highest standard of medical care for a peacetime Army and dependents. This actually is the starting point in our professional training program.

Now what about the qualifications of our Regular Corps as it exists today to accomplish the first mission, that of being ready for mobilization? As you know, almost 100 percent of the Regular corps, of necessity, during the war period of four to six years had to fill staff and administrative assignments. A few months ago, the War Department required that all technical services make a survey of the existing Regular corps, and this survey was for the purpose of awarding what they call a "constructive school credit." We had to survey every officer in the Medical Department, and, depending on that man's age, his length of service, the schools which he had attended, and the assignments which he had held during the war, he was awarded a constructive school credit. The next slide. Here are the results of this survey as far as the Medical Department is concerned. The

military school system is arranged as follows, first our basic course, our advanced course, Command and General Staff College, Armed Forces College, Industrial College, and National War College. When this survey was made we had 1,110 officers in the Medical Corps, Regular Army, and this was about three months ago. Of the Regular corps, 140 had the age and the experience which would give them credit for the basic course. We had 275 whose age, length of service, schools they had attended, and their assignments during the war gave them the equivalent of the advanced course. But notice this--that 582 or more than one-half the corps had the experience and military education equivalent to graduation from the Command and General Staff College. So we must agree, that over one-half the corps either had attended the Command and General Staff College or held assignments during the war which gave them the experience equivalent to the education provided by the Command and General Staff College. Seventy-two were given credit for the Armed Forces Staff College, 15 for the Industrial College, and 26 for the National War College. It is generally felt here that the majority of our officers can successfully fill a staff or command assignment in the Medical Department during the war, having gone no further than the advance course. We're not going to have to send every Medical Officer to the Command and General Staff school. So you see that for this second mission, the Medical Corps as it exists today is very well trained, with over one-half of the entire corps having the military education equivalent to graduation from the Command and General Staff College. So at the present time we're very well qualified from the military or administrative standpoint, but we're woefully short as far as our professional qualifications are concerned as brought out in the previous slide. This is the reason why, for the last two years, we have stressed professional training. We feel that we must correct this imbalance in the qualifications of the Regular corps.

Before I go on, I want to inject one thought. That's a word concerning the American Specialty Boards and professional specialization in general. I know that many of us are allergic to the mention of the word American Specialty Board. I know that there is certainly some difference of opinion with respect to this marked trend toward specialization. I frankly admit that we here in the office are somewhat allergic to certain actions of the American Specialty Boards. Of course the pendulum has swung far toward specialization in American medicine. As General Willis and his crew down at Medical Field Service School say so many times, "Don't fight the problem." Let's not fight this problem of specialization. Whether we like it or not, whether we agree with it or not, the yardstick of professional attainment in American medicine today is certification by an American Specialty Board. The outlook and attitude of the medical student is different from what it used to be. The peak or goal when we graduated from medical school was graduation from a four year course in an accredited school, a one year internship, and then the practice of medicine. That's no longer the peak and the goal of the medical

graduate today. His peak or goal has been elevated about three or four years. Graduation from the medical school and a one year rotating internship, he considers merely a stepping-stone toward three or four years more of training toward specialization and board certification. This is a truth--a fact--let us not fight it, but accept it as a truth and fact. Unless we can convince the medical school graduate today that the Army has and can provide training toward specialization and board certification, you're never going to get him in the Army. Let's realize and accept this. We have the means to provide that training. Let's take advantage of it. We're beginning to see reactions now against specialization. As I say, the pendulum has swung far, but we're beginning to see some reactions. Indiana, for instance, has set up its own State Board for general practitioners. Just recently there has been organized along with other academies, an Academy of General Practitioners. That's sponsored by the American Medical Association. The University of Colorado Medical School has recently organized a three year residency training program for the general practitioner. Very shortly, we in the Army will have our own three year training program for general practice. This marked trend towards specialization is certainly a matter of great concern today of American medicine and of the American Medical Association and the Specialty Boards. When it comes time for this pendulum to swing back, I'm sure that the Army Medical Department will be right there and lend its weight to bringing that pendulum back to a neutral or normal position. But for the time being, regardless of our personnel views, let's accept these truths and facts as something beyond our control. Let us not fight it but rather make our plans and solve our problems accordingly.

MEDICAL DEPARTMENT EDUCATIONAL SCHOOL SYSTEM

Now after a study of these requirements which I just outlined in these slides, The Surgeon General's Office formulated a post-war educational school system for medical officers. Most of you are familiar with it and I'm going over it just briefly. Tab No. 1 is a diagram of this system. As I say most of you are familiar with it and I'm going over it very briefly, because I'm going to spend most of my time on the Residency Training Program. This system is now about 75 or 80 percent in operation. The newly commissioned officer will come in the service, and he will first be sent to a Medical Field Service School for a four months' basic branch course. This course in general will correspond to the old prewar course which was conducted at Carlisle and with which you are all familiar. There are two reasons why we have not started this course as yet. First, we haven't had anyone to put in the course and second, we still have a few ASTP officers to train. We have a class at Brooke now, and we're getting our last group of ASTP officers in the service in July. That will be the end of the ASTP program. The first peacetime four month class will be in September of 1949, and the individuals to go in that class will be those of the 108 interns who we're getting in July of

this year for our Army hospitals, who elect to enter the regular service. On completion of their internships they will be sent to this first course at Brooke in September 1949. Now after that course, a man may go to one of several places. He may go out to his first duty assignment, or he may go into the professional training program as a resident in a specialty. Some of the MSC officers may go directly into supply training, which is in operation at the present time at the Army and Navy Medical Procurement Office. Incidentally, our first basic science course began last week. I will have more to say about that in a moment. A few of the Medical Service Corps officers may go directly into our opticians course. We conduct this course every seven months. The next class begins the 5th of April; this course has been continued in operation from wartime. All of the Veterinary officers, after they finish the basic branch course, will go tbethe Meat and Dairy Hygiene Course at Chicago. This is a three months' course, and we conduct the course every three months, at the present time. The Army, Navy Medical Equipment Maintenance Course is conducted at the St. Louis Medical Depot. This is a six months' course and has been continued in operation since the war. The course in Hospital Administration we're conducting at the present time at the Brooke Army Medical Center. The next course will begin on the 10th of May. I'll have more to say about civilian institutional training in a moment. We keep from two to three hundred officers at all times in civilian institutions for both professional and administrative training.

Now the advanced branch course. We have a technical and administrative phase of the advanced course. That's a four months' course, required of all Medical Department officers somewhere between the third and tenth year of their service. Our first class in that course will be conducted in August of this year. You recall on the chart that I showed you up here on the board, a minute ago, we had 140 officers who were given the constructive school credit of only the basic course. Those are the individuals who will attend our first advanced course to begin in August of this year at the Medical Field Service School. Not all of the officers will take the professional phase of that course. The Veterinary officers will go to the advanced Veterinary medical course which will be here at the Army Medical Center. That course has not begun. The Laboratory Medicine course will be held here at the Medical Research and Development School. We're going to scratch preventive medicine for the time being. We are not going to attempt to duplicate the training that is being given by civilian institutions in preventive medicine. We have sent 51 officers to civilian schools for a one year course in Public Health and Preventive Medicine in the last three years. We're sending now from ten to twelve every year. We're going to continue to send doctors to the civilian schools for that training. Advanced dentistry will be here at the Army Medical Department Research and Graduate School, and the first course is to begin in September of

this year. Now the other training included on this chart is our administrative and technical training at the Command and General Staff school, the Armed Forces College, National War College, and Industrial College. At the present time we have seven men in the Command and General Staff school. We can get all the officers who can be made available for training in the Command and General Staff School at the present time. The Armed Forces Staff College is a course that's conducted twice a year, and we've been sending two to three officers to each course. Quotas are very limited, but we have been sending either one or two officers to the war college each year. To Industrial College we've been sending from two to four officers each year. Now that, in brief, is the overall Medical Department school system. As I say, the system is about 75 to 80 percent in operation, the purely military training is represented in the basic branch course, the tactical and administrative phase of the advanced course, and the service schools at the top right-hand corner.

RESIDENCY TRAINING PROGRAM

Now I'd like to discuss our residency training program. As you know, after the war as officers were returned from overseas and units were inactivated and officers could be made available for training, we put them into the general hospitals, in what we call refresher training. For one year this refresher training went on, and about 400 officers took part in it. During this year, the possibility was explored of establishing within the Army, permanent, formal, approved, residency training. We went to the American Medical Association and to the American Specialty Board, and it was decided about a year and a half ago that we could establish and support adequate residency training. We started this program one year ago this month in eight of our permanent general hospitals. The American Medical Association and the American Specialty Board have been quite surprised and pleased with the progress that we have made during this year in conducting and operating teaching hospitals. The American Medical Association sent out a warning last summer that residency training in American medicine was far over-extended. There are three times the number of men in residency training today as there were before the war. They sent out the warning that there were too many residents in many hospitals, many of the hospitals could not meet the standards that they required, and so we thought it was a good time to take inventory--check up and see what we were doing and how good our own hospitals were. We invited a group of 27 civilians, all of whom were medical educators, men who were well acquainted with residency training, and asked that they go out in teams of three to these eight hospitals and stay there at least a week and clearly evaluate the training program in that hospital, compare it to the residency training that they knew back at their own civilian hospitals, and give us their advice. We asked that they survey the hospital from every angle, from the amount and variety of clinical material, the physical plant, the instructor or

permanent staff, the attending or consultant staff which we had there. They came back and all sent in a very long, detailed report. These reports were analyzed and finally at a meeting of the executive council of that group with representatives of The Surgeon General's Office, it was decided to contract somewhat in our residency training program. It was decided to discontinue residency training at Beaumont. It was decided to put Madigan and Percy Jones on a standby basis. It was decided to not open Valley Forge, at the present time, for residency training. This is no reflection at all on those hospitals that were closed or placed on a standby basis. They simply did not have sufficient clinical material in enough specialties or they didn't have sufficiently highly qualified instructor personnel, and there is nothing that The Surgeon General's Office can do about it at this time. They were just not available and those hospitals were so located geographically that it was somewhat difficult for them to get sufficient consultant time. That in general was the reason for putting these hospitals on a standby basis or closing them. Just as soon as we are able, and I think we'll be able to within one year, a year and a half, possibly two, we will go into Valley Forge, as well as Percy Jones and Madigan, and establish residency training. We hope we can do it within one year. (Now will you turn to Tab No. 2 please). That's the status of our present program with regard to approvals in the residencies. When we discontinue these hospitals and put them on a standby basis, that leaves us five teaching hospitals in this country. That's Brooke, Fitzsimons, Letterman, Oliver, and Walter Reed. We've added Gorgas to the list because Gorgas is approved, and we have some residents training there. I might mention here a word about the Tripler General Hospital. As soon as the New Tripler Hospital is open we're asking the American Medical Association to send Doctor Reed over to inspect this hospital for residency training, and we're sure that we can set up Tripler for training both for interns and residents. Now that's the present status. The P means that that residency is permanently approved by the American Medical Association and the respective Specialty Board. The T or temporary approval means that it was given full approval and that our men are getting credit, but the hospital is subject to a final inspection at a later date. Frankly, that time is whenever the American Medical Association can get to it. However, our men in all those residencies where you see a P and T, are getting full credit by the board. The R means that the residency has been recommended by the American Medical Association for approval to the American Specialty Board, but we do not have the final action on it. Now in that program you'll notice that there are 71 residency training programs in our five teaching hospitals. Fifty-seven of them have permanent or temporary approval and 14 have been recommended. You can rest assured that we're working on those 14 and have been for some time. It takes just about a year to get a residency approved, because the application goes from the hospital to the American Medical Association. They get out when they can to inspect the hospitals; then their recommendations go to the Specialty Board. The Specialty Board meets once a

year or sometimes twice a year, so on the average it takes us about a year to get one approved. Tab No. 3 will give you a further status of the residency training program. As to whether or not it's approved or for how many years. They recommend a residency for one year approval, two, or three years. In other words, you can train a man just his first year, or you can train him two years, if it's a two year approval; or you can give him his full three years training in that hospital. It gives you the number of spaces or residents authorized in that hospital, the number of vacancies, and those that will be present 1 January 1948. That's just information that you can take with you concerning the program. The reasons for the vacancies at the present time is just because the Personnel Division cannot make any additional officers available for training. If they could possibly make them available they would certainly be in there. We have a total of 318 spaces; I think there's a summary on the back of that Tab No. 3 which gives you the spaces. A total of 318 spaces; plus 21 spaces at Gorgas. Tab No. 4 will give you the names of individuals in training in each specialty and whether or not the man is an assistant resident, a resident, or a senior resident. You can look through and see each one of your specialties there, the men who are in training, also the chief of the service. I thought that might be interesting information for you to take with you. Now will you turn to Tab No. 5. That's a schematic representation of the way that we feel these residencies should be organized. In other words, this isn't 100 percent, but, in general, you should have one intern to each ward and you should have an assistant resident in that specialty supervising the intern. I realize that in some instances you will have to have one per two wards or one per three. You have to balance your clinical material against the physical setup of the hospital. In general, a resident or a second year man, a man in second year training, will have the supervision over two or more assistant residents, two or more wards. Your senior resident, your third year man in training will have supervision over the entire service whether its the urology, or ear, nose, and throat, or general surgery and so on. At some places there may be sufficient clinical material to have two senior residents on a service. That in general is how the program should be organized. That's known as the pyramidal system. Now all of the trainin will be in the pyramidal system. Some of it may be in columnar system. What I mean is that you may have two men as assistant residents, two of residents and two senior residents so you don't have to pyramid. That's true especially in psychiatry. Now this system that you see there is patterned after the system as utilized in the best civilian teaching hospitals. We have gone to the better civilian teaching hospitals here and in Philadelphia, New York, and Boston, and it's patterned after those hospitals. There must be very close supervision, observation, and evaluation of the residents by your permanently assigned staff, your chief of service, your educational committee, and your consultants or what we now call attending staff. This is a competitive program as you can see. In some specialties you're going to have more first year men than you can

possible utilize as second year men. It's competitive and those men who have dropped out because they can't meet competition may go out to a station hospital for an assignment and get back into the program later on. We may interest some of them in general practice, in training for general practice, and so on. We are endeavoring to increase the spaces. We want the maximum number of spaces that we can support. Beginning next week representatives from The Surgeon General's Office will visit your hospital, will sit down with your educational committee and your chief of service, and will ask for the information on the other side of that sheet. In other words, the view is to setting up the maximum number of spaces. They'll find out the amount of clinical material that you have; how patients are treated; number of deaths; number of autopsies; number of operations, major and minor; and so on down the line. They will determine--with your chief of service in each specialty, and your educational committee, and yourself--the maximum number of residents that can be trained in that hospital. The American Medical Association gave us a formula on which to work. We go quite a bit by that formula. So much clinical material in various specialties for so many men. We have to stay fairly close to that formula. The American Specialty Boards do not always agree with the American Medical Association on the number of available spaces, so we have to balance the American Medical Association with the Specialty Board with our own ideas and arrive at what we think is the maximum number we can put in. Now when this survey is completed I think we can increase slightly the total spaces. I think it will mean some increase; but I don't know how much until we complete these surveys. The next Tab is Circular No. 5. Circular No. 5, as you know, is the circular that is the basis of this entire training program. We have revised this circular, and here are the major changes. I'm going over them very briefly. We have reduced the number of required conferences, only two now are required. We have deleted the hours devoted to basic science instruction. Basic science instruction will be taught within your hospital as far as possible at the bedside. I see some of you have some academic instruction going on with the university connected with the school. That's all right; keep it up; it's a good idea. The hours prescribing the training day have been deleted. It was a mistake to have ever put it in there; there is no such thing as hours of training for an intern or a resident. An intern or resident is on duty twenty-four hours a day in the Army just as they are in civilian hospitals. You arrange locally for their time off but as far as we're concerned here, it's twenty-four hours a day just as they are in civilian hospitals. The mixed residency has been eliminated, and I'll point out why a little later on. We have learned that Circular No. 5 is not in itself sufficient. Operating teaching hospitals was just as new to The Surgeon General's Office as it was to you as individuals in the teaching hospitals. We're asking that each hospital write out a detailed, coordinated plan for training in each one of the specialties in which they are conducting training. Now the reason for that is this. We've learned that the training in

internal medicine at Walter Reed will differ from Fitzsimons, and they differ from Letterman, and so on. They'll vary, and so we are asking that each hospital write out a detailed plan for the training program in each specialty at their hospital. We suggested this some time ago, and Letterman has written out such a program, and it arrived in this office yesterday. Let's consider it briefly—Example: Dermatology: Every Monday from 8 to 9 they have a dermatology staff conference at the University of California, and the University of California dermatology staff is responsible for that hour every Monday morning. Every Monday morning from 9 until 11:15 on ward 33 they have a dermatology clinic, and one of their consultants is responsible for that hour of instruction. Every Tuesday from 11:15 to 12:00 there is an x-ray therapy conference that is, the men in dermatology attend this conference of x-ray therapy, and they designate the instructor responsible for that training. So you can go through this program and see that every hour of every day is included, the place where it's held, and the individual who is responsible for that training, whether it be the chief of service, assigned staff or one of the attending staff. In addition, they have one hour listed here on Wednesday from 8 to 9. Didactic instruction in dermatology, and on the next page they list one hundred and fifty four hours of didactic instruction in dermatology; that's all given by the Univerity of California. Doctor Teddie is responsible for four hours of embryology. Doctor Stewart is responsible for six hours of bacteriology. Doctor Morro, eight hours of chemistry, and so on. One hundred and fifty four hours during the year of didactic instruction and the man who is responsible the instruction. Now this is excellent. There's only one suggestion, Colonel Winn, that I would make. If you could, in addition to this schedule, write out a word description of the activities and responsibilities of your first year residents in dermatology and the activities and responsibilities of your second and third year residents. If, later on, you could add that to this program, you'd have a program that we could take before the American Medical Association or the Board of Dermatology and say, "there is the training program at Letterman in dermatology." Exactly what it consists of, who is responsible for it, every hour of instruction, and the activities and responsibilities of the first year men, second and third year men. We're going to ask that each one of the five teaching hospitals draw up such a program. That is a detailed program of the training in each specialty in which you are conducting training. Now just one other word, the matter of clinical records. The American Medical Association and Specialty Boards, the American College of Surgeons also, insist that clinical records be available for residents in training. As you know clinical records in Army hospitals must go to the St. Louis Adjutant General's depot after six months because of a tie-in with the Veterans' Administration. To meet this requirement, we are now purchasing photo microfilm equipment for eight general hospitals. At these hospitals all clinical records will be microfilmed and the films will be filed permanently at the hospital. The material will be available for statistical analysis by the residents and this will enhance the training program. This will furnish excellent material for research projects. It is anticipated that this equipment will be available in about sixty days.

INTERN PROGRAM

Now Tab No. 7 is the intern program. In these five teaching hospitals, we have at the present time 160 spaces for interns, i.e., the clinical material and facilities will support 160 interns. We have vacancies for eight interns at Gorgas. Last year we had only about 50 applications for Army internships. This year we have 322 applications for Army internships, more than six times the number. Tab No. 7 will give you the names, age, and the school from which the intern comes and whether or not he was in the upper third or middle third of his class. I might say that these interns are selected, 108 of them, only from the upper and middle third of their class. We did not select any from the lower third of their class. There are the names of those who will go to Brooke, 24 of them; Fitzsimons, 20; Letterman, 22; Oliver, 13; and Walter Reed, 27. Gentlemen be sure, be absolutely certain, that these interns get a good, well rounded internship. Frankly, several of the deans of the medical schools have told us that they will form their opinions of an Army internship after they hear from these men. It's exceedingly important that you give them an excellent internship. If you will do this, I believe that in the future, we will not have any difficutly at all in getting all of the interns we can possible use, from the upper and middle third of the graduating classes, and I'm sure that if you give them a good internship, we will not have any difficulty in keeping a relatively high percent of them in the Regular Army. The great majority of these individuals will report on 1 July 1948. There are a few schools still on the accelerated program, 4 or 5 schools that graduated medical students in February and March. We are discouraging any of those interns to come on duty in April. We would much rather they come to the hospital in July because of administrative difficulty later on when we get out group next year. However, we have told them that their internship will begin in July. Of those that graduate in March or April, and we are requesting that they be sent to their internship in April, we are granting this, so you may expect a few, not more than two or three at each hospital in April. A great majority of them will come to you in July, and if they come to the hospital and talk to you about it, discourage their coming on duty in April; however, if they insist upon it, we will grant their request.

TRAINING FOR GENERAL PRACTICE

Now a word about training for general practice: All I can tell you now is that we are at the present time drafting a three-year residency training program designed to train a good general man--a general practician. We don't like the word general practitioner. In the main this training will be at general hospitals other than our five teaching hospitals. In other words we are going to call upon Valley Forge, Percy Jones, Madigan, Beaumont, Murphy, Tilton, McCormack, and Army & Navy to conduct this training for general practice. It is possible we may use the larger station hospitals

in this program. We will have that program out within about a month. We will be down to see you and outline it and so on. It is hoped that we will be able to interest quite a few of the regular corps or quite a few of the youngsters coming into the regular corps in this training program. The University of Colorado is just beginning a similar course this year, and Dr. Jenson who is head of the post graduate school told us that he has more applicants for the training than he can accommodate. Three years training for general practice. We hope to interest some individuals in it.

BASIC SCIENCE TRAINING

Tab No. 8—that's basic science. Practically all of the American Specialty Boards require some training in the allied or basic sciences. They are very indefinite or hazy about what they require as to whether it should be a full time course or part time course, or whether it should be taught on the ward and so one. There is considerable divergence of opinion right now in American medicine as to how you should conduct basic science training. The medical schools, a few of them, in the last two or three years have organized courses in basic science instruction. We have sent, as you know, quite a few officers to these courses. In the main it has been a repetition of first year anatomy, physiology, and pharmacology. It's frowned on in general by the Speciality Boards. There are several schools of thought on the subject. The thing has never jelled at all as far as American medicine is concerned. At a meeting of the Speciality Board and the American Medical Association—the advisory council of the Speciality Board—they spent one whole day last year in Chicago discussing this very problem and they all expressed their views and the conference ended right where they started. About a year ago we invited Dr. Irvin Paige to come and help us on this problem. Dr. Paige is director of Research and Laboratories of the Cleveland Clinic. He came in and we discussed basic science training with him. He had a few revolutionary ideas in basic science instruction with reference to how you should teach the basic science as applied to clinical medicine. We have been working about a year on the thing now and finally we decided that we could conduct our own course in basic science, and Tab No. 9 will give you the approach that we are taking. First, teach Category I subjects. Teach those subjects which the body utilizes as a whole and metabolizes. That is the essential substances such as water, electrolytes, carbohydrates, proteins and so on. Then teach the aberration in handling these substances that is effected by modifying agencies such as bacteria, virus, neoplasams, cold andheat and so on. Third, teach the study of the different systems; gastrointestinal system, nervous and renal system in their normal and abnormal handling of the basic substances as a result of your category 2 subjects. Now that is sort of a new philosophy in teaching basic sciences. We had to have a faculty so Colonel Moursund who has charge of that program spent six months in going all around the United States, and with Dr. Paige's help picked out 55 of the top notch men in their subjects.

In other words he picked the man who knew the most about the metabolism of water in the country regardless of who he was. When Colonel Moursund presented this problem to these 55 men, almost without exception they were very enthusiastic about it so much that they agreed to come to Washington to spend four or five days of their time to teach their particular part of this course. The course began last Monday at the Army Research and Graduate School. We have 27 officers enrolled in the course. This course is an experiment. We hope and believe that it will be a successful one. We have invited the medical schools and all are sending representatives to it. We think that there is a possibility that it may become the accepted method of teaching basic science. If it is successful we will conduct the course every year. The tabs that I mentioned will give you a complete background for it. They are tabs 8 and 9. Tab No. 8 gives you the complete background of the course and Tab No. 9 gives you an hour by hour breakdown of the subjects. So much for basic science.

CIVILIAN INSTITUTIONAL TRAINING:

Since all of the necessary training in the Medical Department of the Army cannot be conducted by the Army, we have made use of training in civilian institutions. During the last fiscal year we sent some 304 Medical Department officers out to civilian institutions. I can show you on this chart. I realize that you can't see the details on this chart, but at least we can see the trend. In January of 1946 we had 26 officers out in civilian institutions. We immediately set up more courses and encouraged our officers to apply for these courses, and you can see how it went up from 26 to a peak, during February 1947, of 272. The number came down a little here in June, July, and August of 1947, because there are few courses given during the summer months and another reason was that we ran out of money at the end of the fiscal year. We received our new appropriation and the number has gone back up now to around 200 officers in civilian institutions at all times. During the month of December there were 197 officers in civilian institutions. They have included courses for medical officers, dental, veterinary, Army Nurse Corps and so on. Each corps has received its share of the available funds in accordance with its needs and availability of its personnel for training. The courses for medical officers have covered the entire field of medicine; the courses for dental officers has been mostly orthodontia, periodontia and oral surgery; courses for the Medical Service Corps have been hospital administration, business administration, sanitary engineering, and nutrition research. As I said a moment ago, during the last three years, we have sent 51 officers to take the full one-years' course in public health, mostly at Johns Hopkins and Harvard, although we are branching out now at Columbia and the University of California for this instruction. Gentlemen, we are still getting too many personal letters asking for civilian institutional training. Acquaint your personnel with Circular No. 32.

Circular No. 32, dated 7 March 1947, goes into detail and tells how a man applies for a course in a civilian institution. There is a definite reason why it has to be done that way. To send a man to a civilian institution we have to know almost two months in advance; we have to go to the War Department, they go to the Army, and the Army has to go to the institution to draw up a written contract--whether it costs us any money or whether it's no cost agreement. There's only one mistake in Circular No. 32. Applications should come into this office, Attention: Personnel Division, not Education and Training, as is stated here. So acquaint your people with that. We are having less trouble but still too many personal letters to The Surgeon General or to General Armstrong or to chief of Personnel, or chief of Training asking that "I would like to have such and such a course on such and such a day, the chief of service says it's o.k. and concurs," but that's not enough information. Obviously, it should go through channels. We have to know whether you have to have a replacement during the time the man is gone and so on; so acquaint your personnel with Circular No. 32.

R.O.T.C. PROGRAM

The last thing that I want to discuss is the R.O.T.C. program. Before the war we had authority for only 23 Medical R.O.T.C. units, and year before last that's all we had authority to reactivate; just 23. We reactivated 20 of the 23 schools. The Surgeon General at that time felt that we could not afford regular officers for this assignment so we recalled to active duty reserve officers and sent them out as PMS and T's. This program worked just fairly well. This year or last year I would say, we convinced the War Department that to fulfill the requirement of the Regular Army and the Reserve we would have to have R.O.T.C. in all 66 accredited medical schools. We surveyed the 66 schools; we approached the dean with a new proposition, and most of you in the Army are well acquainted with it--that if they would accept an R.O.T.C. unit, we would pick out a young enthusiastic regular officer and send him there as PMS and T for a minimum of at least two years, and we asked that the school or affiliated hospitals train that officer in one of the specialties. We attempted to combine our professional training, our residency, with R.O.T.C. R.O.T.C. is not a full time job in the Medical Department. There is a maximum of four lectures per week. I realize there are some other duties that take more than four hours, but that's the maximum number of lectures. We approached the deans with this proposition and 43 of the 66 were very enthusiastic and accepted R.O.T.C. units. Our Personnel Division selected 43 of our most able young regulars, men who are interested in professional work, men who had combat experience, who would be a good professor of military science and tactics, and put them out into these assignments for two years. We brought them all to Washington here for a three-day conference to orientate them in their job, orientate them with personnel problems, our professional training program, internship problems, and so on. This program has worked out beautifully, so much that we have

9 schools now that have written to The Surgeon General's Office asking that we talk to them with a view to establishing R.O.T.C. units in their schools. That's quite different from two years ago when many of them would hardly consult with us at all. Now the results of this so far is that we have doubled our schools this last year and we have tripled our enrollment. Last year as I said earlier we had only 50 applications for internships, this year we have 322 applications. These results, I am sure, were due mostly to these eager, young PMS and T's out there presenting the Army's problem, presenting our training program, and so on to the medical students. I think that the Armies are doing an excellent job in operating these R.O.T.C. units. Turn to the last two Tabs 10 and 11. Tab No. 10 will give you the names of the 43 medical schools in which we now have an R.O.T.C. unit, also the name of the PMS and T and the specialty in which he is being trained by the school or affiliated hospital. Turn over to the last page of Tab No. 10, please. Now, there will give you the dental R.O.T.C. schools contemplated for this year, 1948; there are 19 of them. It will also give you the veterinary R.O.T.C. units now contemplated for 1948 of which there are 6, and pharmacy schools contemplated of which there are 4. We do not have, as yet, the authority of the Department of the Army to activate these new units. We expect to get it this week. Do not contact these schools yet. We have the understanding with the Ground Forces that representatives from The Surgeon General's Office with a representative from the Army Area Surgeon's Office will make the initial contact. We have definite reason for that; because the PMS and T has to be assigned from here. It has to be determined in what specialty they can provide training; then we go to Personnel Division and find out if they have such a man available, and so on. So we'll make initial contact with the school with a representative from your office. After we once get the units established, then of course, we'll turn it over to the Army area to operate. Tab No. 11 is just a brief summary. There are 67 approved four-year medical schools here in this country. There are six in which we are not particularly interested. Alabama, Albany, Bowman-Gray and Utah have a very small enrollment. Some 50 or 60 students in the entire school. It is not economical to put an R.O.T.C. into these schools. Tennessee and Southwestern are both schools still on the accelerated program where their students get no summer vacation but go to school all year for three years; therefore they can't attend the R.O.T.C. summer camps. That makes six that are unacceptable. Twenty were established in 1946; an additional 23 in 1947, so that leaves 18 units remaining. The first fifteen are the ones we are primarily interested in. Rochester, College of Medical Evangelists, and Maryland are still somewhat in doubt. We must clear up certain points on these three before we approach the school.

CONCLUSION

Gentlemen, I have presented here the basic framework of the education and training program for officers. I think that by taking

full advantage of these training opportunities, we can, within a period of eight to ten years, develop and maintain a group of regular medical corps officers who will be professionally capable of rendering the higher standard of medical care and who in the event of another war will be capable staff officers. I am sorry we have no time for questions. We'll be here all day tomorrow and Saturday, so if any of you have any problems or questions I would welcome a visit from each one of you to the Training Division to discuss any phase of the training program. I would certainly appreciate your opinions and recommendations on it.

L. GENERAL DISCUSSION OF PERSONNEL SITUATION..Colonel Paul I. Robinson

General Bliss, Army surgeons, hospital commanders, most of the morning is to be devoted to personnel matters. Following my remarks, Colonel Amspacher will discuss, at some length, the present procurement program and what we are trying to do. Then Colonel Epperly, Colonel Maley, Colonel Goriup, and Colonel Vogel will discuss special problems in the Dental Corps, the Army Nurse Corps, the Medical Service Corps, and the Women's Medical Specialist Corps, respectively. Colonel McCallam will discuss veterinary personnel matters and make remarks on other matters.

We have not included anything on our program today with regard to the enlisted personnel program. The question as to whether or not it is about time for the Medical Department to again get its own medical enlisted corps, as it had before the war, and as the Navy Department now has in its Hospital Corps, has been raised. The Plans Division has a study on its agenda and of course you all will hear more about that at a later time. Civilian personnel problems have also been eliminated from our agenda today. We feel, in general, that everyone is handling his civilian personnel problems in a very fine manner. We realize that the different shifts that we have had from enlisted personnel to civilian personnel, and vice versa, have been tremendously annoying. I think that you will all understand that these things are without our control and we hope, as you do, that they'll all be stabilized as soon as possible.

Also we have not included on this program today any special section for our career planning. However, on the wall in back of General Willis, there are a number of career programs posted so that any of you may look at them and see what we are trying to do. I feel that during the next conference of this type, the Personnel Division will devote its entire time to career management which will be well under way by that time. Furthermore, we are not going to talk today about Reserve problems. We are worrying about the number of resignations that are coming in from the Reserve Corps. We have no really good method of evaluating what these resignations mean. However, I am sure that within a very few days a letter will go out either to the Armies or direct to as many Reserve officers as we can reach to try to stop these resignations. We think that probably a number of Reserve officers are remembering that they came in as 1st Lieutenants, whereas there were men that were not in the Reserve Corps that came in as Major and they feel that possibly the best thing to do is to get out of the Reserve Corps at an early date. We are not going to discuss that problem today.

The acute problem that the Medical Department is involved in now is the matter of procurement of officers. We are going to hear from the Dental Corps and the Nurse Corps, who also have acute shortages.

For that reason, my remarks will be limited to the Medical Corps. I have a chart here that will indicate what the general situation is to be over the next two years. You can't easily read the chart, but it really matters not at all. This is the stage we are now in as of January 1948. The blue is our Regular Army, amounting to a little over 1,100 doctors. The green is volunteers, in other words, Category I, VII or VIII officers. This yellow group is the ASTP group, or the non-volunteers, Category V. You'll notice this little bit of blue up here on top--that is the surplus that we have been discharging from the service during December--1,300 ASTP's. In other words, as the Training Division says, it costs a medical school more to educate a student than he pays in tuition, so for every one who comes into the Federal service, why should not the Federal Government pay to that school a certain sum of money calculatedto be the difference between the cost of his education and the tuition he has paid in.

This plan is thought of because it will cause the deans of the schools and the instructors in the schools to be interested in having some of their graduates go into the Federal service. All of these plans have difficulties. In the first place, they would all require legislation, and anything that requires legislation encroaches on our time. Another scheme that has been suggested to cover the period until something can be done to get more medical officers available is to employ civilian doctors on a part time or full time basis. This plan certainly is one that we must have to cover the emergency period, which we are bound to have no matter how good procurement becomes. General Bliss mentioned yesterday that that part of the previous bill which was not passed last year has already been re-submitted to the Department of the Army for re-submission to the Congress at the present session. However, there are a few things that are wrong with that scheme also. The bulk of doctors that are available for employment under this scheme are now with the Veterans Administration, and it would place us more or less in a position of being an encroacher on the Veterans Administration, another Federal service, if we go into employment on any large scale.

You will note that the Regular Corps has barely held its own. Integration has just about balanced separations. If this situation is not corrected in the next fifteen months, all able-bodied medical officers must be sent overseas, and the hospitals and medical installations in the United States must be almost entirely staffed with civilian doctors on part time or consultant basis.

Our experience in the past few months indicates that we cannot interest enough doctors in Army medical service to fill this deficit by the ordinary methods of procurement. A program has, therefore, been evolved, all of which has not yet been approved by The Surgeon General. It has been discussed with several General Staff officers in Personnel and Administration GSC, and would probably be sanctioned by them. It

includes:

1. Commissioning in the Regular Army 200 to 300 doctors per year in 1948 and 1949 who are in residency programs in civilian hospitals, allowing them to remain in their civilian residencies, even allowing them to compete for another year of formal training in civilian hospitals, while on active duty status.

2. Commissioning in the Medical Corps Reserve 200 to 300 interns per year in 1948 and 1949 in civilian hospitals, allowing them to finish their internships on active duty status and to compete for and accept residencies in civilian or Army hospitals, provided they come into the Regular Army.

3. Obtaining 130 residencies in civilian hospitals throughout the United States and having them reserved for Army use.

4. Procuring 400 to 500 officers per year in 1948 and 1949 from civilian, ASTP, and Army intern sources, allowing them to compete for the 130 Army and 130 civilian residencies.

5. Requiring every participant in this program to serve as a duty officer in the United States Army one year for each year of formal post-graduate training, whether in a civilian or Army institution.

6. Endeavoring to commission 100 to 300 mature, well-trained doctors directly in the grades of Major, Lt. Colonel, and Colonel.

7. Expanding the post-graduate teaching program as rapidly as possible, both in the United States and overseas, so the Medical Department will have to depend on civilian institutions only for exceptional training;

8. A general improvement of medical service in the Army, including the providing of living quarters, human understanding, social events, and high standards of medical care.

9. Advertising continuously for doctors to do one or two years of duty in specific jobs. We are now advertising 143 positions in the European Theater and are publicizing specific jobs in the United States. Most such assignments would be as Reserve Officers on active duty.

I think this program is worth implementing to the utmost and I think it is the only program which offers any reasonable possibility of success.

I have tried to analyze this program in terms of what it will mean to the Army in the years 1948, 1949, and 1950. This analysis can best be presented on these three charts. In 1948, 600 would be on a civilian training status, 100 on an Army training status, and the remainder, or 550, would be on a duty status. In 1949, a composite of both years of

procurement would provide 600 in civilian training, 100 in Army training, and 550 on duty status. In 1950, 800 would be in civilian training, 500 in Army training, and 800 on duty. Also in our estimate we have provided for 400 separations.

This plan when contrasted with our situation, if nothing is done, will give us 2,600 duty officers instead of 1,100. I want to make it clear that this plan is not an approved one. The Surgeon General has authorized me to present it to you today for your comments. We want criticisms and we hope you will be free in making them in order that we can make a firm program for actual procurement. In order to expedite the program, however, it is necessary that discussion be delayed until the discussion period.

M. PROCUREMENT PLAN.....Colonel William H. Amspacher

General Bliss, gentlemen: Colonel Robinson has covered the personnel shortage picture. He has offered some possible solutions. Now my job and the job of all of us is to try to implement a procurement scheme and then to alter it as required. Later speakers will reveal some of the individual problems of various corps--service corps, nursing corps, veterinary corps, dental corps; so I shall deal only with the over-all problem. Several months ago we embarked upon a program designed to procure the required officers for the Medical Department, both for the Reserve and the Regular Army. Naturally, the Regular Army portion of it comes first, because it's our more immediate problem. The Procurement Branch was established in the Personnel Division, and definite plans were made for a procurement drive with two definite phases of accomplishment being recognized; the phase one objective being to remove all possible administrative bottlenecks in the way of commissioning, and to provide the necessary mechanisms for commissioning of personnel of all corps within the Medical Department. This phase is now well along toward being completed with only Reserve components remaining to be completed. Phase two--a publicity and educational campaign, directed at the civilian medical, dental, veterinary, nursing, and allied personnel, was begun at approximately the same time as phase one but at a considerably slower pace. It had to be at a slower pace. We couldn't put ourselves in the embarrassing position, which we have been in from time to time, of going all out on a drive to procure personnel and finding that when a man came in and said, "I am ready to hold up my hand," we had to say to him, "well, that's nice, except that right this minute there is no way we can take you into the Army." We didn't want to be in that position again, so we have been working on the administrative end of it, and I think it's pretty well straightened out. I think it is. Now for phase two--at least what I have chosen to call phase two—the publicity and educational campaign. It's this part of the show where you gentlemen must take over the lead roles. There isn't too much that we can do in here, except coordination to get in your way, I suppose. From the outset we have been working under the assumption that there are many men fitted to be Medical Department officers who are definitely interested in the Regular Army but who have needed a little push to get them to apply for a commission. And there are many others who could have their attitude toward an Army career changed by properly directed publicity or propaganda drives. With the exception of the supply and administration portion of the service corps, the Medical Department is not considered to be a bargain and the public is not on a buying spree. Definitely not, we've got to sell it to them. Now just what are our plans for selling the Medical Department? We're going to depend on

the following things. First a well-coordinated publicity campaign for the purpose of educating the public with particular reference, of course, to personnel eligible for commission. We must dispel the doubts about the efficiency of the Medical Department that have grown in the minds of so many physicians, dentists, and allied personnel. And we must present to them a true picture of what the Medical Department is today and what we can make it in the future. Second, we must make personal contact with the greatest possible number of eligible civilians both in and out of uniform and personally show and tell them just what we have to offer. A good many things will be necessary if this program is to be successful. First, we've got to contact every accredited medical and dental school and be certain that every student in that school knows about Army internships, both medical and dental, and about a career in the Army. We've got to contact all the veterinary schools for the same purpose, and educate them as to what we do have to offer. We must contact all the nurses training schools for the same reason and educate the nurses who are being trained. And here we've got to put some emphasis on the new reserve program because it's a drastic change from anything that's ever been in existence before. There has never been such a thing as this, as the reserve nurses' program. We've got to dispel doubts in their minds about being called to duty against their will and many other things. We've got to contact all the schools who train potential applicants for the Medical Service Corps, particularly the allied science branch. A list of the more important schools will be supplied to you because that is quite a list. We've got to contact all the schools who train potential applicants for the Women's Medical Specialist Corps. Here again we will try to dig out for you appropriate schools and supply you with the necessary list. We've got to contact all hospitals, especially those conducting graduate educational programs. We must talk to the interns and residents as well as members of the attending staff and the visiting staff. We must attend all possible professional society meetings. We must be prepared to furnish speakers for any and all occasions. We must personally contact all reserve and A.U.S. officers now on active duty and urge them to apply for regular commission. We must contact personally all Army interns whom we now have in uniform to get them to apply for regular commission. We must move expeditiously on all applications which we do receive. We have lost innumerable people during the integration phase, because we offered a man a commission and then defied him to get it. And that is no laughing matter. We actually did exactly that thing. The Adjutant General contrived in his "losing division," to lose the biggest part of the applications, and what he didn't lose we managed

to lose for him. And we can't talk a man into coming into the Army and then put a guard in his way and say, "No, we've changed our minds." We must secure the proper publicity through public and professional media for any happenings of interest within our respective spheres of activity. This last named action--publicity--rapidly becomes a project of its own, and one of no mean statute. The civilian experts with public information estimate that a period of roughly two years is required to effectively influence public opinion, so we've got to get after it now. Now what can we do here in the office? We're going to adequately publicize any and all actions that stem from the office, both direct and through your respective headquarters. We're going to write and publish informational booklets and pamphlets for the use of all of us; for our use--for your use. We're going to supply you with pertinent material for any of your campaigns that you want to put on individually. We're going to supply pertinent material in magazines and journals which are national in circulation. We're going to arrange for the coverage of all national meetings of civilian professional societies, with displays, speakers, etc., again either direct or through your respective headquarters, according to geographical location or according to suitability of available speakers. We will organize and direct the over-all publicity program. And we shall arrange for speakers on call for any organization that wants a speaker; any recognized organization. What action does this leave for you? It leaves for you the securing of adequate local and regional publicity through both public and professional media; the adequate utilization of material being furnished to you; and that you must cover local and regional professional meetings located in your assigned area; and forward to The Surgeon General's Office items or happenings of interest that you feel should have national coverage and which we can get. And you must furnish speakers, either on direct application or as requested by this office. So much for the general publicity campaign. We'll now turn to the personal contact angle. Practically all the personal contacts will be made by you or your personnel. The only prospects whom we can see in this office are those who come of their own volition, and those who are on duty locally. These contacts are the most important action any of us could take toward procuring Medical Department officers. It is imperative that no possible contact be passed over. We've got to give them all a chance. This campaign could very well fail or succeed depending on whether certain prerequisite conditions are met. First there must be sharp delineation of responsibility so that none of us can blame the other for omission. The person who makes the contact or has an interview must know the product he is trying to sell and be sold on it himself. We must never sell a prospective applicant anything we wouldn't buy ourselves. Everything said and done

must be in good faith. We in the regular corps are, unfortunately, rather poorly informed about our own corps. A sorry picture and this must be corrected. Information is not reaching the individual, and this condition, unless corrected, could quickly nullify all of our other efforts. As an example, late in 1947 there were fifty resident positions made available to personnel who would apply for Regular Army commissions. Many weeks after this information was supposedly disseminated, we found young reserve officers right here in the Washington area who had never heard of such a thing. Didn't even know it existed. Even today, in spite of all that's being said about it, there are still many A.S.T.P. graduates and many of their commanding officers and contemporaries who don't know that an A.S.T.P. student can get in the Army after he has been on duty for six months. Some of these boys can be sold if they are told. That must be corrected immediately. We had originally planned to pass out to you bundles of mimeographs this morning, but we were unable to complete the whole set. So we have changed our plans and will mail the entire set to you as a kit along with a cover letter. I want to take up briefly the papers that will be in this kit. First, there are listed areas of responsibilities, by Army. There is nothing new in this of course. But it does bring you a list of the installations, that is pertinent civilian installations, within your area which you may or may not already have available. When you look at this list you will soon notice that almost the entire responsibility falls on the Army Surgeon as far as the contact and the publicity is concerned, with the only exceptions being in case of intimate contacts already in existence between schools and hospitals in civilian life and the various general hospitals. These have all been noted. I suppose you will all be mad and chagrined, when you get the next paper and notice that we have requested a bunch of reports. We didn't do it just for the sport of it, but it's the only way we can find out what you are doing; it's the only way we can find out what's going on in the over-all picture. Next, there will be a memeographed stock speech in this kit we are sending you. Now I don't know whether you'll like this speech or not, I don't particularly like it myself. I didn't write it so you can say whatever you want to about it when you get it, and it is not designed to be delivered as written. It's a guide. A lot of us have a lot of trouble preparing a speech, and we need a guide of some kind; we need to know what to say. In addition to helping the person, it's a well-known fact that when a man gets up to make a talk to the public, unless he does have a guide, he's very likely to say the wrong thing and emphasize the wrong thing. Next, there will be an extract of all the commissioning regulations. This may be unnecessary, but we thought maybe you could use it so we've gotten it together. We've tried to put in in usable language so that

in one place you will have the regulation and the actual wording in the regulation which governs the commissioning of personnel of all corps in the department. And there is a list of talking points that can be emphasized both in interviews and preparing talks . There will be question and answer booklets covering the Medical Corps and the Dental Corps. These are designed to be used by you in any way you want. They are designed for public consumption and can be sent out or handed out to potential applicants. We can make available to you all the copies of these question and answer booklets that you may want. And last, there will be a mimeographed pamphlet entitled Appointment in the Officers' Reserve Corps for the Army Nurse. In all of our efforts to procure officer personnel, we must always remember that our standards are not to be lowered. I would like to quote just a few figures to show you how the integrees were screened. You may or may not have heard these figures before. In the Medical Corps, there were 999 applications received during the entire integration. Out of the 999; 498 of them were accepted for appointment; 488 were rejected; and of those who were accepted by us, only 374 of them accepted their commission. Therefore, we got a total of 374 Medical Corps officers. And here, I think, would be a good place to repeat what I have said about obstructions in the way of people getting commissions. The number accepted for appointment by us was 498; the number who were actually commissioned was 374; and a goodly number of those who declined, declined because they didn't understand what their rights were; they didn't know that they could get leave without pay at the time of their commission; they didn't know they could get any leave to straighten out their family affairs before they left home; they didn't know that we could give them delay enroute; they didn't know anything. I mean, we just went out and said here, here's your commission, take it or leave it on that certain day. A lot of them chose to leave it. If we handle them the same way, they'll choose to do the same thing in the future. In the Dental Corps, the picture is much the same; 729 applied, 332 were accepted; 392 rejected; 234 were finally commissioned. It's the same way in the rest of the corps. The number rejected means we tried to screen them well. I mean, we had improvement of the corps; we had elevation of standards; we had high professional standing and everything else in mind. And that's the reason a lot of these people couldn't make the grade on integration. What's the story today? We're under a new system, and we're confronted with many of the same problems. We've got a tremendous number of people, relatively, to be appointed in the higher grades. These people must be very, very carefully screened, or we're going to be in trouble. But we do have the Evaluation Board now already functioning. These evaluation boards are located at all named general

hospitals and we certainly should be making use of them. We can handle many more personnel than are being processed through those evaluation boards today, I assure you. We've found, as you can see, that we have two missions—first, to get the right people to accept the commissions; and second and of equal importance, if not more important, to keep the wrong people from getting them. It's a sad thing to have to say but there are certainly a goodly number of doctors and dentists throughout the country between the ages of 40 and 50 who would be perfectly content to draw a salary until retirement. Some of them obviously don't intend to do anything else, except draw that salary. We must watch them. Now, there's another subject that we must cover. I purposely left it out of the main body of my paper, because it is a rather abstract thing and one which is difficult to discuss. There are a group of factors that Colonel Robinson lumps together and very appropriately calls "Army charm." We have a feeling that there is nothing more important to our program than this very thing. What does it mean? It means our respect for each other. The little things that one officer tries to do for another to make his life a bit more pleasant. The friendly social gatherings; the advice that the older officer gives the younger; personal interviews; the sincere farewell and best wishes that go with an officer and his family when they leave a post. And whether or not we have forgotten it, this is the very thing that attracted many of us into the Army. In spite of the other fine selling points that we may have, we cannot sell the Army without its attendant charm both for an officer and his family. The disregard of this old traditional Army charm has reached its lowest possible ebb in the handling of the young officers now with us who were educated under the A.S.T.P. program. Despite the fact that these men are our greatest potential sources of procurement, we have chosen in many instances to practically ostracize them, because they were educated at government expense. We have not stopped to realize that these men were educated with a different ideology than most of us. They were schooled to believe that their education was not complete until they were certified by one of the American Specialty Boards. We are not in the position, any of us, to sit as a high judge and decry the goal that these men have set for themselves. Instead we must be sympathetic and try to rationalize the demands that we must make upon them. They have often criticized us because we have not given them adequate professional leadership. And we are not in the position to say categorically that they are wrong. Instead we must show them what we are trying to do and solicit their help. We must keep our own shirts clean by making the very best possible use of every doctor and dentist who is now on duty. There are still many hundreds of these youngsters on duty, and I am certain that a high percentage of

then can be converted into first class, enthusiastic, regular army officers; but not by whipping their ears down. You just can't do it that way. These boys have their own ideology; they've got their idea of what an educated doctor is; what an educated dentist is, and we can't change it by whipping them. It just simply cannot be done. All of us have been very prone to become angry at the very mention of the word A.S.T.P. And I must admit that from some of them we have taken some pretty severe punishment, but we cannot, we're just simply not in the position to ride herd on these boys and on their own thoughts. Many of us have sons, brothers, cousins, and uncles, etc., who are in the service; many of them new in the service, and we do everything in our power, every one of us, to try to place these relatives and these friends of ours in the position where they can be certified by the American Boards; yet, at the same time, we stand up and criticize other youngsters for wanting to become American Board members. We're not very consistent. And we may say, "Well, you can't make American Board members out of all of them." I didn't say you could. But you don't need to isolate that man from all his hopes and all his desires. When you do have to put him out in a job where he is isolated from the work he likes and means so much to him, you can at least tell him why he's out there. This certainly isn't intended as a criticism of anybody. These remarks are not aimed at anybody. We're all guilty of it. But it's ideas and it's attitudes we've got to change if we ever want these men to come into the Army. The position in civil life of the medical profession, dental profession, and allied professions today is such that these men don't have to take a whipping from us, and they have no intention whatsoever of doing it. None whatsoever. These boys are not going to come into the Army, if we get them, for any patriotic reason. They are going to come into the Army because we've got something to offer to them. And we do have something to offer to them. We've got a wonderful training program. It certainly takes some time and some selling to get that training program over to people concerned. They have been so completely filled with doubts, many of them, about the sincerity of those of us in the Regular Army that they only want to buy one thing and that's "put me in training now and leave me there." But they can be talked out of it. A great number of them can be shown. And over a period of time they can be properly educated and a high percentage of them can be converted to other types of work, as required. All the activities we have outlined will of course require funds for travel, per diem, and other expenses. We were unable to determine just what the status of your funds were; so, to be on the safe side, we asked that funds be earmarked for each Army Surgeon in the amount of $12,000 for the remainder of the fiscal year. This represented, of necessity, somewhat of a guess inasmuch

as we had no way of knowing just what your expenditures would be. This money was not approved. But the Director of the Budget offered an alternate solution which is probably all right. A directive is now going out of the Department of the Army to each Army Commander suggesting that funds be made available to his Surgeon to carry out the necessary procurement program. This may or may not prove to be a very satisfactory solution. But if it does not the Director of the Budget says that there's one way we can get the money actually in our hands and that's to go to the Chief of Staff and ask his permission to do so. And I assure you that if you don't get the funds you need by the directive that's going out now, we are prepared to go to the Chief of Staff and procure the necessary funds. Well, we've made enough demands on your time. Let's turn the picture around for a minute. What can you do to us? What can you expect of this office? Well, we set the thing up, good or bad, and it's our responsibility to see that it's carried through. Certainly we will have to coordinate the entire effort. We'll have to move speakers from one Army Area to another Army Area in accordance with availability of speakers to cover certain topics. We'll try to take any action required. You can rest assured that your suggestions won't go unanswered. Well, we will need suggestions from every one of you as to what is not going as it should be in the program and what we can do to improve it. We're in position, I think to secure any required administrative change that may be necessary to put the campaign over. I mean, if something is unworkable in the regulation that governs commissioning of personnel I think we're in position to do something about it. We have the complete backing of the General Staff. They are going to let us do anything we want to within reason; anything that we can show them a reason for, we're going to get. There doesn't seem to be much doubt about it. We are at your service. I say that sincerely. You're going to have things come in to you that you are not in position to handle. You're going to have requests for speakers; you're going to have requests for representatives; you're going to meet things from time to time that you can't handle, and that's what we're up here for. And the other things we won't take as our responsibility are things we don't hear about. Thank you very much.

N. DENTAL PERSONNEL PROBLEMS. . . . . .Colonel James M. Epperly

General Bliss, and Gentlemen: It is well known that we all have troubles in the Medical Department, but it is felt that the troubles facing the Dental Corps today are particularly serious and critical. I mean today, because they are presently facing us both in numbers and among the specialized groups. A few days ago a requisition was received from the Far East for 165 dentists and, due to the very limited number who have suificint time to serve, only 40 of this number could be approved. This requisition was for May shipment of this year.

I would like to go back just a bit in the history and past events to bring us up to the dilemma we are facing today. In 1939 Congress passed an Act authorizing 316 dental officers for the Regular Corps, and 265 were tendered commissions before hostilities began, at which time the granting of commissions in the Regular Army was terminated. We conducted the dental service of the Army during the war with 265 Regular Army officers and a total strength of 15,000. During the Fall of 1945 other branches of the service were gradually lowering their separation criteria, but due to the procurement program the Dental Corps remained at 39 months. It was obvious that this was a very unhealthy circumstance and some corrective measures were indicated. The Navy was in a much better position and was prepared to reduce its separation criteria commensurate with other branches. With the view of alleviating this situation to some extent, the President issued an executive order transferring approximately 800 Naval dental officers to duty with the Army. This helped materially, and the separation criteria was consequently lowered to 30 months.

After a nation-wide appeal for 500 dentists for voluntary service, over a period of approximately six months a total of 15 was realized. It was necessary that drastic steps be taken if the separation criteria was to be lowered so that dental officers who had served a long period during hostilities could be released. The War Department placed a call on the Selective Service for 1500 dentists and, as a result, received 900 additional dental officers for service with the Army. So, with the 800 from the Navy and the 900 from Selective Service and approximately 150 volunteers and 250 Regular Army, we had a total of 2150 dentists on duty in the Army at the beginning of 1947, at which time the separation criteria was lowered to conform with the other branches of the service to 24 months.

During the year of 1947 the results of our procurement program amounted to 10 new AUS commissions who were immediately ordered to active duty, and 30 Reserve officers who requested recall to active duty.

There has been some criticism concerning our young dental officers on duty with the Army, but it must be said in their behalf that the

treatment they have received in the Army has not been the best. As you know, the dental ASTP program was terminated in September 1944, and none of these students were able to receive the benefits for a longer period of time than 14 months, and that isn't a very great contribution towards training; also, at the termination of the program, many of the students were told by people in authority that they were unequivocally released from the service, which led them to believe that they would not be called back. They subsequently finished their dental training and established themselves in business—many of them going in debt. It was at this time that the Selective Service contacted them for further service in the Army, and this certainly did not create a very good feeling among this group. Since we were endeavoring to replace hurriedly officers who had been in the Army for 30 or 40 months, most of these officers were immediately assigned to stations in the ZI and overseas without the benefit of the short indoctrination course at Brooke Army Medical Center. It is for these reasons that the young dental officers are not very receptive to our strong appeals for further service with the Army.

Our strength at present has been reduced to 1,550 by the separation of those officers during 1947 who met the separation requirements. Our present requirements are approximately 1,850, leaving a shortage of 300. However, in spite of this shortage, it will not be too distant in the future that we will look back at the beginning of 1947 as a Utopia in regard to dental personnel.

As related earlier, the majority of the dental officers on duty with the Army today were procured during the year 1946; and since we are operating on a two-year separation criteria, the greater losses are to occur during 1948. As a result of the integration program conducted during 1946 and 1947, the Regular Army Dental Corps has built up to 433, and we have on duty approximately 150 Reserve officers; a total of 583 officers remaining at the end of this year.

The requirements for the universal military training program will be 1,200 additional dental officers. The authorized strength of the Regular Army Dental Corps is 743, and if we are successful enough to completely fill up the Regular Army, plus the volunteers who are now on duty, we will have a total of 900 dental officers against the requirements of 1,850.

During 1946 and 1947, 709 applications for the Regular Army Dental Corps were processed in The Surgeon General's Office, with 381 rejected and 328 deemed as acceptable by The Surgeon General's board. The total realized of this number was 222. The difference between the number acceptable to The Surgeon General's board and those actually commissioned was a result of physical disability and declinations received from many at the time they were tendered the commission; the declinations accounting for a vast majority of these.

A large number of those applying for the Regular Army during the integration program were of the upper age group who were eligible for the rank of major. Many of this group were good officers with good Army records and were worthy of a commission in the Regular Army. However, this has resulted in upsetting our linear list to some extent. As you know, we are allowed a certain percentage in each grade and we now have only 70 vacancies in all the grades above that of first lieutenant, so any procurement to be made in the future will of necessity have to come from the younger group.

In addition to the losses among the category V officers, the ones who express a desire to be released from the service at the earliest possible date, we are facing the loss of some of our senior officers as a result of the retirement feature of Public Law 381. Some of these colonels are now occupying important assignments and it will be difficult to replace them. I hope this is fully understood when the senior grade is more desirable and considered necessary to you people in the field on occasions when it appears that a rather junior officer is being assigned to the position.

The complete apathy towards duty with the Army among the civilian dentists is not fully understandable, as we believe the salary is adequate and if the retirement feature is considered, compares very favorably with civilian dental incomes. There is no question that Army service in general has been pretty well de-glamorized since hostilities ceased, and this circumstance is reflected quite materially by the number of vacancies that exist at both the Naval Academy and West Point. We have great confidence in the newly established Procurement Division in the Surgeon General's Office. We feel that competent officers have been assigned to this division, and that if they are not able to get them in the Army it will be a most impossible task.

As related previously, a strong appeal must be made to the younger dentists in the country. There are approximately 2,300 dentists graduated in the United States annually, and plans have been made through the Procurement Division for a senior dental officer to visit each school, relating to the graduating class the many benefits derived from duty with the Army. The results of these visits in 1947 in connection with the internship program were quite gratifying, and it is hoped that the interest we can create for service other than the internship program will meet our expectations.

Provisions are being made to establish the dental ROTC training at approximately 20 of the schools in the country. These units created a great amount of interest in service with the Army among the graduates previous to hostilities and we feel that it is safe to assume that we can get the same response in the future.

We are again operating the dental internship program at six of our general hospitals; this very important training was discontinued

during the war. We have, at present, 25 Reserve officers in this training, which number has been increased to 50 beginning August 1948, and it is felt that this number is sufficient to care adequately for attrition of the Regular Army. It is generally believed that each hospital can handle six such interns and since we are increasing the number from 25 to 50, some hospitals that are not now conducting this training will no doubt be asked to do so. We are very proud of this training program, and with the use of the dental consultants, I think justly so. I am sure that it is the best that has ever been given in the Army and most outstanding in the country as a whole.

We have given a number of our younger outstanding officers graduate training in different civilian institutions of the country. This training has been of a specialized nature leading to a Bachelor of Sciences degree in dentistry. This training is to qualify some of the members of our branch to meet the American Dental Association specialty boards and then return to our general hospitals with the idea of establishing residencies in these specialties.

We are seriously interested in the field of dental research and are making preparations to make competent investigations along this line. With this in mind, capable officers have been selected and are presently being given the necessary training to carry on in this field. This training is of high level leading to the degree of PhD in the field of biochemistry, pathology, etc. It is felt that the people previously assigned to the dental research field with the Army were not sufficiently prepared to fulfill the mission.

Particular attention is being given to the career management of the officers of the Dental Corps, as with the Army in general. It is expected to ascertain in the first few years of each officer's service, any particular talent or ability in the many fields of dentistry and to maintain his assignments accordingly and caution is exercised in channeling his career.

Preparations are being made to introduce legislation allowing us to put civilian dentists on duty at our various posts, camps, and stations on a contract basis. The remarks that Colonel Robinson made about subsidization of dental training are being given very serious thought, and I understand that it is being sponsored very strongly by the Navy. Of course nothing could be realized from any subsidization program for a number of years, and since the solution of our problem must be immediate, this cannot be considered too seriously at present.

It has not been necessary to utilize the provisions of AR 40-510 in respect to civilian dental treatment in the past. With the loss of such a great number of dental officers it is hoped that the dental treatment of our Army personnel in many areas can be maintained under

the provisions of this Army regulation. This is a very cumbersome procedure as the regulation now reads, but steps are being taken to get it streamlined so that individuals at stations where the dental facilities are not adequate to maintain the dental treatment can be sent to civilian dentists and the whole procedure very much simplied.

Our immediate future in the Dental Corps is not very bright.

O. NURSE PERSONNEL PROBLEMS.....Lt. Colonel Agnes A. Maley

General Bliss, Hospital Commanders and Army Surgeons: The problems of nursing personnel reach far and wide. I would like all of you to bear with me in that all your nursing problems are our problems, and we are vitally interested in each and every installation. There is no challenging the fact that all hospitals benefit by having on their staff a group of efficient nurses, well satisfied with their present assignments and duties.

Since the Medical Department of the Army is becoming more and more a teaching organization, both regarding the health habits of the nation, and the young medical officers entering the service for specialized training, it becomes increasingly important for our officers, particularly those in the Regular Army, to understand the Army nurse, the aims and goals of our Corps, and the reason why we seek a particular combination of nurse-supervisor-teacher in those young women entering the Corps for active duty today. And, as usual, it is our Army surgeons and hospital commanding officers to whom we turn when we want to accomplish something for the Nurse Corps and the good of the Army as a whole in the shortest possible time.

Both military and civilian are not very well informed as to the place of the Army Nurse on what we have come to call "our medical team". Many doctors feel that nurses "take too much responsibility"--that they are "too important"--and many worry that nurses in the higher grades may be resented by young first lieutenants of the Medical Corps. But our new doctors and nurses who have transgressed must be taught that, so far as we are concerned, nurses were given rank to make them more effective as nurses. That nurses in the higher grades are there because they have given much time to their jobs, and are deserving of some tangible compensation. While it may be necessary for nurses in administrative positions to carry the responsibilities of those positions, the nurse-doctor relationship, professionally speaking, has never changed.

Nurses who have been with the Army for a long period of time know that the standards of civilian institutions have been raised through the years, not so much by the efforts of the civilian hospitals, but by the progress made, largely through wars, by the Medical Department of the Army. The permanent commissions granted nurses in April is another step forward--not alone for the Army nurse, but for the profession as a whole. But, since we have stepped out in front again, it is the solemn responsibility of the Army to see that the nurses we have on duty in our hospitals realize and accept the responsibility that goes with it. Incidentally, that is why nurses appointed to the Army Nurse Corps must be graduates of accredited schools of

nursing giving standard courses of instruction--why those schools must give courses in the four basic branches of nursing: medicine, surgery, pediatrics, and obstetrics. This also is why we prefer nurses with postgraduate work or experience in psychiatry, operating room, anesthesia, administration, communicable diseases, and personnel management.

The M.O.S. which was developed during the war is an important and valuable factor. We try to assign a nurse in her M.O.S., because we are fairly certain she is professionally qualified to do that type of work. We encourage nurses to specialize in their interest, and assign them to that specialty. At present we have an M.O.S. for administrative nurse, for neuropsychiatric, operating room, anesthesia, obstetrics, and general duty nurses. We will re-establish M.O.S. for communicable diseases, pediatrics, and fever therapy. We know that most of them do better if assigned wherever possible in their M.O.S.

We also have nurses who are well qualified, and educated to be instructors in their various M.O.S.'s; yet, we have no instructors M.O.S. at the present time. This is a little touchy subject. The only way we can assign nurses properly is to advise the various installations as to their qualifications. This does not always meet with the approval of the commanding officer; but we have no intention of assigning your personnel to definite jobs--we can only advise of their qualifications. So we are asking you to help the young doctors and nurses already on duty with the Army to realize the mission and the obligation of the Army nurse in her responsibility to the Medical Department.

The most serious problem at this time is the general release of A.U.S. nurses. I do not like to quote figures, as figures can easily be misinterpreted, but these are the facts. Our approximate calculated requirement in the Regular Army, one to ten basis, is 6,270 nurses; authorized strength manning level figures, 5,500; authorized minimum Regular Army strength, 2,558. We must supplement strength with Reserve nurses up to 2,942. To date, we have 5,018 nurses on duty--approximately 925 Regular Army, 861 Reserves, and 3,232 A.U.S. Just realize the number of nurses we will lose if we are not able to encourage more nurses to join the Reserves. The Reserve nurses now on active duty will be given a preference of category to sign as to their desires to remain on active duty. All others will be released from active duty. Attention is invited to Circular 79, pars. 4, 5, 6.

(1) There is no legal authority for retaining nurses on active duty after 30 April 1948 unless they are members of either the Regular or Reserve Corps.

(2) Individuals now on active duty who desire an appointment in the Reserve Corps must apply for a Reserve commission not later than 1 March 1948 under the provisions of War Department Circular 97, 1947, as amended by War Department Circular 364, 1947.

(3) Officers who do not accept an appointment or whose applications are disapproved will be separated from the service not later than 30 April 1948.

(4) Officers who initiate travel incident to processing for separation because they have indicated that they do not desire on Officers' Reserve Corps commission will not be authorized to change this declination prior to separation and will not be recalled to active duty for a period of two years if they later apply for and receive an Officers' Reserve Corps commission.

(5) Acceptance of an Officers' Reserve Corps commission will not affect current Army of the United States grade or present volunteer category status.

We are now taking in Reserve nurses who have had no previous military training. The records of these Reserve nurses are now being processed in our office and, if they reach the requirements, will be commissioned as 2nd Lieutenants and sent to the Army Medical Center at Brooke General Hospital, for an eight weeks' course in Army nursing. These nurses will then be reassigned. After a year of active duty, if she should desire to join the Regular Army, or stay on active duty as a Reserve, her year's records and efficiency reports will be reviewed in this office for recommendation to Regular Army or Reserve active duty. We will have to depend on reports from all of you, and your chief nurses, so that we can retain the best qualified nurses in the Army. Many of the Reserve nurse records were being held in the Army headquarters for further information. We have requested that they all be sent in, and they are now being processed in this office.

We have many queries from the field regarding our Regular Army integration program. Nurses who have applied and have appeared before the screening board, but have not appeared on any of the prepared lists, are becoming understandably concerned about their appointment. Many of you have written for information--which we have been unable to supply, except the barest outline, and this on a confidential basis. Information concerning the relative standings, scores, or other confidential matters pertaining to any applicant, cannot be given out.

The program of integration must be completed by 16 April. In the meantime, the applications of those nurses who have not appeared on any of the lists are in one of the following categories:

1. They are awaiting confirmation by the Senate.

2. They are being reviewed by The Surgeon General's Office.

3. They are being held in The Adjutant General's Office for additional information.

4. They have been rejected and are being held until the end of the program for announcement unless the rejection for physical disqualification, overage, or technical test failure. These rejections have been notified.

Because we are not permitted to give out any other information, we would appreciate it greatly if, upon your return to your installations, you would kindly advise the nurses in all cases that they will be notified by 16 April and that, until such time, they have more chance of being appointed than of being rejected, since the rejections are running less than 10 percent. Nurses who have not heard from the Board should be encouraged to join the Reserve, and stay on duty until they hear from The Adjutant General as to their appointment.

We also get many complaints that nurses have not had correct information in the fields. Many of the nurses are under the impression that when they are appointed an officer in the Reserve Corps, they will be automatically called to duty. This is not so—she must apply for recall to active duty, and we will recall her--not necessarily in the rank she holds as a Reserve nurse, but in lower rank, as we need them. All the recall papers are reviewed, and assignments made in our office. Those who get a regular Army appointment, and are not on active duty, are also assigned to active duty from our office.

On assigning and reassigning personnel it takes a great deal of time, and, in order to replace key personnel in time, we must have requests a month or two ahead. We cannot always have a replacement physically present unless, of course, it is key personnel, and then we try. We have nurses to assign and reassign in every installation where we have nurses in the world—both in the Zone of Interior, and outside bases.

Recently we sent out a request for names of nurses with no previous military service, or those who have been back long enough to be sent to foreign duty. One Army reported that they had no nurses P.O.R. qualified, but that is difficult to believe. We had no intention of sending all of them any time soon, nor before we had concurrence from your hospitals. The main purpose for this was not to send nurses overseas who were not qualified. What I mean is—that we have had nurses volunteer for overseas

duty who have been in the Zone of Interior only a short time; then when they arrive at their new station, and they do not like it, they request to be returned to the States because of their length of service overseas since 1945. We have been sending only volunteers--but, of late and in the future, if we get no volunteers, we will be forced to send those who are P.O.R. qualified.

We are trying to encourage our nursing section to establish eight hours duty. I know, with the shortage of nurses, it is not always possible; but all other nursing services in various branches are doing eight hour duty and that is our goal. To not keep up with the best practices established in other Federal and best civilian institutions will discourage nurses from joining our Corps and requesting extended active duty. It would also be appreciated if the Army chief nurses or hospital chief nurses would be consulted when a proposed T/O is discussed. Recently we sent to the field a ceiling of female officers. We had hoped to get the ceiling raised so that eight hour duty could be established. One Army sent back that we had assigned them over twenty nurses too many. As this ceiling had been carefully studied, we feel the error was made in the field in not discussing the nurse quote with the chief nurse; because, although we know that we recommended a minimum ceiling to all Armies, we had hoped that an eight hour duty base could be established.

I will pass over quickly the latest educational program:

Arrangements have been made with the University of Pittsburgh to conduct a two-week workshop in Nursing Administration for Army nurses only. It is desired that chief nurses in leading administrative positions attend this short course.

These nurses will be selected by name in this office and a TWX will be sent to commanding officers and Army Area surgeons for release of named nurses for the purpose of attending this course. It would be appreciated if concurrences be given in all instances.

The aim of the workshop is to assist nurses with practical problems in nursing service administration. It is conducted on a conference basis with discussion of specific problems, with field trips to hospitals for consultation with hospital nurse executives; importance of developing supervisors and head nurses and delegation of responsibility will be stressed; selection of professional nursing personnel and methods of evaluating their services will be reviewed; other subjects discussed will be responsibilities of chief nurses, how to judge the quality of nursing service, and its value of in-service training program.

We have also sent out sample books on standardization of the nursing service in Army hospitals. These books will simply be used as guides in an effort to standardize our nursing service to aid all Army personnel, and not to hinder them. We appreciate all the comments and recommendations that have been sent in from various installations. These reports are very valuable, and the nursing procedures will again be reviewed, and all your changes and comments will be considered in the actual procedure book before it is approved. Let me point out again that it is merely a guide.

Thank you very much for your kind attention. I consider it a privilege to be here. If you have any personal questions or requests, Colonel Phillips, our chief nurse, or I will be in our respective offices, and will be glad to see you.

P. MEDICAL SERVICE CORPS PROBLEMS. . . . .Colonel Othmar F. Goriup

General Bliss and gentlemen. We have only been in business for about three and one-half months. We have many projects on which progress is being made but which are not completed, so I can't give you a report of positive action that has been taken. I would just like to go over briefly some of the questions that are given to us most frequently by officers visiting our office.

The one that seems to be paramount is that on many occasions we are told that we have some weak officers whom we have integrated, especially in the supply and administration segment of the pharmacy, supply, and administration section of the Corps. I believe that the evaluation board who selected these officers for appointment did the best job they could when the only things they had to go by were the records. I believe that we had many able men who were integrated; however, I also feel that it behooves all of us to make every effort to evaluate and reevaluate the officers that were integrated, especially during this probationary period.

After June of this year we will still have a year and a half to revoke the appointments of the original integratee. I believe that we should make every effort to be accurate and thorough in the remarks that we put down in executing efficiency reports on these officers. Regulations require that efficiency reports for the integratee be so noted. I wish everyone whould make sure that that is done. The reasons for revocation are a little more detailed than was the old class B system of attempting to class B an officer, and I understand that in the last eighteen or twenty years the Army did class B three or four officers, so I think we should take advantage of the present machinery that has been set up to get rid of any of the weaker officers that we might have.

The remarks that the surgeons make that they have some weak men in the Regular Army might or might not be predicated on the premise that they feel that they have some officers present at their stations now who are better qualified in their opinion than the man who was actually integrated. We have no way of knowing that up here. We believe that you have intimate daily contact with them and should evaluate them. The instruments that will permit you to revoke their appointments will be found in WD Circular 281 of 1946, WD Circular 302 of 1946, Department of the Army Circular 49, of 1947, and AR 605-230.

As you know the Medical Service Corps is essentially composed of four sections: the pharmacy, supply, and administration section; the optometry section; the sanitary engineering section; and the medical allied sciences section. We haven't much historical data in the way of utilization of some of the people of whom we would like in the various sections. Also, some of the procurement objectives for these particular types of people are in the nature of estimates, but we are authorized a total of 1,022 Regular Army in the Medical Service Corps and initially they are broken down as follows: In the pharmacy, supply, and

administration section, we have allocated potentially 60 percent of the corps, or roughly 613, as a procurement objective. We have about 673 on hand. That again is not completely accurate since all the figures are not in. It gives us about a 60 overage in that particular section at this time. I believe that when all the data is in that that figure will more than likely be 48 or 50. The reason we are over in that section currently is that we integrated on the possibility of being authorized 1,086 in the Medical Service Corps and we ended up with a final authorization of 1,022. We think that we need 20, and can intelligently utilize 20 optometrists. To date we have one, which leaves us 19 short on procurement. In the sanitary engineering section, we feel we need in the neighborhood of 80. These are approximate figures or roughly 8 percent of the corps. We have 15 and consequently we are short 65. In the medical allied sciences section, we think we need roughly 300 or 30 percent of the corps. We have about 60 which leaves us 240 short in that section.

As I stated before we are currently over in the pharmacy, supply, and administration section. We have each year a competitive tour opening in January and June. We felt that lest we destroy the interest in the Corps that we had better open a few positions--create a few vacancies in the pharmacy, supply, and administration section to enable these men to compete. The vacancies will be few. If we get no attrition from revocation under the probationary period and based on the statistics of deaths, retirements, and resignations, it will be a number of years before we have real vacancies in the pharmacy, supply, and administration section. However, we did receive 136 applications for competitive tour. We screened and rescreened them very thoroughly and we found 10 who in the board's opinion were qualified for competitive tour.

Some of you gentlemen may feel that you have men at your stations who should have been given the opportunity of competing. The individual that you have in mind might be a high type of individual, but when compared with the rest of them, 134, we felt that we picked the best 10 men we could find. In order to prove that we were strictly unbiased, one of the officers that we permitted to compete was colored and five of them will require a USAFI GED Test before they are permitted to compete. We also felt that since we were going to keep the numbers low that we would send them all to the Brooke Army Medical Center. General Willis has consented to accept the responsibility of conducting the competitive tour for the pharmacy, supply, and administration section. That may answer any questions you may have as to why your man was pulled away from you and not permitted to compete at his own station.

We are not included in the procurement act, hence, the only offer we can make to men of the other sections of the M.S.C. is either a second or first lieutenancy. We feel that since the integration program was in effect for almost two years, we secured as many of those people as we are ever going to get, and it would appear that our only course of

procurement of that type of individual in the future will be either through our R.O.T.C. program or through the colleges and direct from civil life. If and when we get that type of individual on our competitive tour, we intend to handle each one of them separately and not send him to Brooke necessarily but to handle each man as a separate entity.

Another problem that confronts us is there was a certain amount of dissension among the civilian scientific societies when the Medical Service Corps was being formed. They didn't think that you could mix water with oil by grouping together people anywhere from a nonhigh-school graduate to PHD's. In our few trips to the conventions of the various scientific societies and in speaking with the permanent secretaries of such societies, the presidents and deans of schools, students, and especially those scientists that we currently have on duty with us, we find this dissension is not as acute as we were led to believe. It is not as prevalent now as it was and it is getting better. And I believe that we can disspell it completely by personal contact with people in civil life in these various sciences and certainly with intelligent utilization of those few that we have.

I also believe that if we are ever going to coalesce the Corps with all of these various types of people the best place to start the coalescence would be right in our own family, and I think it would be splendid if the surgeons would make available the conference rooms at their hospitals and urge Medical Service Corps officers there to have little professional meetings. Perhaps once a month or more often. Have book reviews, review some of the journals. There is an abundance of pertinent information available to them. We will try to get a letter out to you at a later date giving you more detailed information on our ideas on this together with a bibliography.

The last thing I would like to take up is that a lot of the men in the field are interested in the insignia. We had quite a go-around with the insignia. I believe that if we had had the time, money, and the opportunity to define the over-all mission of the Corps and gave it to some civilian agency, they might have come up with a honey of an insignia. We didn't have the time or the authorization so we tried to do it here. We asked The Quartermaster General to give us as many illuminations of his ideas as possible of an insignia. We couldn't get anybody to agree on a herald so we went back to the alphabet proposition and we have an "S" intertwined in an "M" on a silver caduceus hoping that possibly silver caduceus might set us apart from the purely professional man and we wouldn't be in the embarrassing position of being called a doctor, or especially in the midst of an accident having someone say "Hurray, here's a doctor," and your having to tell them you're not. We just called the quartermaster yesterday. They are anxiously awaiting the first sample from the manufacturer. They think it will be there any day, and they tell us from past experience that it takes from forty-five to sixty days to get them in adequate production for sale, so we will hazard a guess and say that the insignia will be ready for sale sometime in April.

Q. WOMEN'S MEDICAL SPECIALIST CORPS.....Colonel Emma E. Vogel

Since the Women's Medical Specialist Corps Division has not yet been organized, this talk will be confined to plans and hopes for the future. Before I continue, I should like to say that all of the general remarks made by Colonel Maley in regard to the integration of nurses are also applicable to the members of the Women's Medical Specialist Corps. Remarks by Colonel Goriup regarding the availability of insignia are also applicable to the insignia for the WMSC.

Almost every day I receive telephone calls requesting information as to the composition of the corps and whether or not psychologists, dental hygienists, and other individuals in allied fields may be commissioned in the Women's Medical Specialist Corps. As you know, Public Law No. 36, which was signed on 16 April 1947, designates that the corps shall consist of only three specialized groups, dietitians, physical therapists, and occupational therapists, who will be in the ratio of 9/10ths of an officer to every 1,000 officers in the Regular Army, but not less than 409 officers as computed in accordance with this chart. The Dietitian Section, 39% or 159 officers; Physical Therapist Section, 33% or 136 officers; Occupational Therapist Section, 28% or 114 officers. Officers required in these sections in excess of the minimum number will be members of the Women's Medical Specialist Corps Section of the Officers' Reserve Corps, which was also authorized by this law. After the integration has been completed, all future appointments in this corps will be made only from individuals otherwise qualified who are members of the Officers' Reserve Corps. This law provides, as stated by Colonel Maley, that the integration must be completed by 15 April 1948. Deferment under certain conditions has been authorized by The Adjutant General, but in no case will deferment be extended beyond 15 March 1948. To date, there have been three increments, totaling 61 dietitians, 53 physical therapists, and 54 occupational therapists nominated. As of this date, 33 dietitians, 35 physical therapists, and 10 occupational therapists have accepted commissions. Since all of the applications have not yet been received in this office, there is no information available at this time as to the number which may be expected to be integrated into each of these sections. Regulations concerning the general provisions of the Women's Medical Specialist Corps are in the process of publication and should be available from The Adjutant General about the 1st of February.

There seems to be considerable misunderstanding regarding the MOS and the abbreviation designation for these officers. In accordance with Department of the Army Circular 17, 9 October 1947, the abbreviation authorized for the Women's Medical Specialist Corps is WMSC, not WMS as was previously announced. The abbreviation for dietitian is DIET., not HD, and for physical therapist it is PT, not PTA as was the case in the AUS status. The MOS designation for occupational therapists will appear in the revised edition of TM 12-406, which is now in the process of amendment. In the meantime, The Adjutant

General has approved the job description and MOS of 3416 for occupational therapists. In addition, the MOS of 4114 may be used by hospital food supervisors who are the chief dietitians in general hospitals.

In regard to the insignia, I just have one point to add. Occupational therapists who are commissioned at the present time have no distinctive insignia. They are therefore authorized to wear the insignia of the physical therapists pending the approval and availability of the insignia for the WMSC which is a silver caduceus with letters WS superimposed.

The general remarks made by Colonel Maloy regarding separation of nurses on the 30th of April are also applicable to members of the Women's Medical Specialist Corps. At the present time this office has no information as to how many officers in this corps may be expected to apply for commissions in the Officers' Reserve Corps with request for extended active duty. We should like you to urge the members of this corps to apply for commissions in the Officers' Reserve Corps, bearing in mind that any officer who has been on active duty or who is now on inactive status may apply. In addition, it is hoped that regulations will soon be published that will concern the commissioning of civilians who have had no previous military service. In this connection, it is anticipated that all officers appointed in this corps who have had no previous military service will be ordered to the Brooke Army Medical Center for the basic course, following which they will be assigned to general hospitals for further experience. After these officers have served on extended active duty for a sufficient period of time to accomplish an evaluation of their professional ability, they may, if they desire, then apply for a commission in the Regular Army, provided they meet all requirements and have not passed the age of 28 years. The procedure for appointment in the Regular Army will then be accomplished the same as for other officers. As soon as this regulation is published, we shall call on you to follow through on the publicity program suggested by Colonel Amspacher.

It is anticipated that training programs for the three sections of the corps will be established at the Brooke Army Medical Center on the 1st of September 1948. If the plan is approved, an applicant, otherwise qualified, who has submitted a written statement to the effect that she will apply for a commission in the Regular Army upon completion of the training program, will be commissioned in the Women's Medical Specialist Corps Section of the Officers' Reserve Corps. The educational requirements for such appointment will be: (1) for dietitians--a bachelor's degree from a college or university acceptable to The Surgeon General, with a major in foods and nutrition or in institution management: (2) for physical therapists--completion of a college or university acceptable to The Surgeon General, with emphasis on physical education; and (3) for occupational therapists--completion of four years of didactic training in a course of occupational therapy acceptable to The Surgeon General. Details regarding the procedure for making application will be

published in a Department of the Army Circular in the very near future.

The career program for Women's Medical Specialist Corps Officers has been given serious consideration and study. In the past it has been noted that some officers have spent their entire military service in a station hospital, while others have been assigned only to general hospitals.

It is recommended that specialization of these officers not begin until the third or fifth year. It is anticipated that a limited number of graduate courses in civilian institutions, some of which will lead to the master of science degree, will be available before the end of 1948. Instructions regarding the qualification of applicants and the method of making application will be published soon. Refresher courses in these specialties in selected general hospitals are also being planned. It is proposed that assignments of individual officers will be on a planned, rotating, and progressive pattern through station and general hospitals, in accordance with the demonstration of increased ability and acceptance of responsibility. However, it is not anticipated that the complete professional training program for the WMSC will be implemented until it is known how many officers have been integrated into the Regular Army.

The organization of the corps is still in a formative stage. It is hoped, however, to establish an organization that will be capable of ready expansion in the event of an emergency, but which at the same time will constantly be working toward improved standards of professional performance and advancement in these specialties. With this as our goal, we hope that the contribution of these groups to the Medical Department will be even more effective in the future than it has been in the past.

R. CLASS 3 INSPECTION AND VETERINARY PERSONNEL.....Brigadier General James A. McCallam

General Bliss, gentlemen, I am glad of the opportunity to appear before you this morning and convey briefly some information pertaining to the veterinary service, particularly regarding inspection at origin, the veterinary personnel situation, and one or two other items.

Class 3 or inspection at origin is the most important of the several inspections with which the veterinary service is charged, not only relative to determining the soundness of the food item and its processing under sanitary conditions, but to insure that the quality of the product complies with the specification and the purchase instrument, thus insuring that the food is nutritiously acceptable.

Inspection at source or origin is a policy of the Department of the Army. Under the provisions of WD Circular 138, 1946, and WD Circular 47, 1947, the army commander is responsible for the accomplishment of inspection at origin of all foods of animal origin in the army area except in those metropolitan areas where general depots are located, and such depots are expressly charged with the procurement of foods. Then this inspection in the metropolitan area is charged to the veterinary service at the depot.

This arrangement has not been entirely satisfactory from the standpoint of command, administration, supervision, and economy and efficiency in the utilization of personnel. We will take the San Francisco area as an illustration. There were two veterinary units in that area, one an Army unit at the presidio, and one assigned to a class II quartermaster installation. The one at the Presidio did no inspection within the San Francisco area but operated in contiguous areas, while the veterinary personnel assigned to the class II installation in San Francisco had no business outside the metropolitan area, and, in fact, could not inspect outside the San Francisco area. This division of responsibility caused so much confusion and lack of efficient over all operation that the Veterinary Division, Surgeon General's Office, initiated a letter to the Manpower Control Group, Department of the Army, recommending that the veterinary personnel assigned to the Quartermaster class II installation be transferred to the Sixth Army, thus making that army responsible for the veterinary service in the San Francisco Area. The Quartermaster General and the Sixth Army concurred and the transfer was effected.

The conditions cited existed to a lesser extent at two other places and were corrected by the transfer of the personnel to Army jurisdiction; in one case the Army headquarters initiated the request.

Emphasis is placed on this situation because it is our firm belief that all veterinary personnel, including veterinary officers doing this type of inspection assigned to Air Force stations, engaged

in the inspection of food at origin should be under the control of the Army, or at least under the technical supervision of the army veterinarian through the army surgeon. This is for economy and efficiency in operation and for the most efficient utilization of available personnel. In this connection, it should be remembered that the veterinary service at general hospitals, ports of embarkation, and class II installations is under the Army. Until such time as a further revision of Circular 138 (1946) is made, we are accomplishing it piecemeal, as mentioned above.

I want you to know our policy regarding the subject and that several members of the Manpower Control Group, Department of the Army, with whom we have talked agree. That is why the several transfers of veterinary units have passed from class II to Army class I control.

VETERINARY PERSONNEL

A condition causing us increasing concern and in which you have an interest is the inability to meet requisition requirements for veterinary personnel (officers and enlisted) in the zone of the interior and overseas. Since June 1946, a shortage of veterinary officers has existed, becoming more acute with each separation because of expiration of term of service or otherwise. This shortage has not only resulted in spreading those available rather thinly in attempting to accomplish our mission and assigned tasks, but it has retarded the Veterinary Corps in the development of its training program and research activity. We were unable to take full advantage of authorized available vacancies for specialized training in civilian institutions. Nor have we been in a position to assign officers for specialized training in advanced courses given at Army schools.

The present authorized strength of veterinary officers, regular and temporary, is 575. With a current strength of 398, we are 177 under the authorized ceiling. Between now and 31 December 1948, 90 category V officers will be separated because of expiration of service, leaving the Veterinary Corps with an aggravated shortage. A logical question would be, "What have you done about it?" Over a year ago we started a program in our attempt to get officers to come on active duty for a period of two years. We went to the associations, had articles written in the periodicals, and wrote to the deans of colleges, but we haven't had much response. Replacements have been negligible in spite of everything that we have attempted. There is one thing that did help us somewhat--our authorized ceiling of Regular Army was set at 186. With the backing of The Surgeon General, a paper was prepared and presented to the Staff, requesting that we be authorized a temporary increase in order to take advantage of the experience of the limited number of officers that desired to come into the Regular Army. The Staff agreed to this, and we were able to obtain about twenty additional officers. Since then we have had some

losses, retirements, and declinations. I think we made a net gain of fifteen. This overstrength, however, will be absorbed by attrition when Regular Army colonels leave on retirement. Therefore, our records on officer personnel indicate that the situation will become increasingly critical with the passing of each month in 1948 and will seriously impair the efficiency of the service, which we are expected to give, through our inability to provide adequate direction and supervision by officers.

Another point I should like to make is the need for the army veterinarian to make inspections of his area from time to time. I think it's especially important at this time that many of the younger officers who are in the field receive adequate supervision by the army veterinarian under the jurisdiction of the army surgeon. The army veterinarian should get out and check his workload in that area, resolve any difficulties that may arise, and provide uniformity of inspection regardless of the inadequacy of personnel strength. We will appreciate your assistance in this matter.

I want to say a few words on the question of inspection of fruits and vegetables at general hospitals. We have been asked on several occasions why veterinary personnel assigned to general hospitals do not inspect fruits and vegetables on receipt, especially for condition and soundness.

Although the veterinary service is specifically charged by regulations with the inspection of foods of animal origin, it is not limited to the inspection of such foods at post, camps, or stations. In some places the inspection of foods of other than animal origin is being accomplished by veterinary personnel. In fact, The Quartermaster General wants the Army veterinary service to perform the inspection of all foods purchased by the Army, including laboratory examination. We are not in a position at this time to take on the vast volume of work such inspection would involve. However, it is our policy that destination inspection of all foods may be accomplished at posts, camps, and stations as far as veterinary personnel are available at such places for this work, particularly with reference to the condition and soundness of such food items. I mention this phase of inspection at general hospitals because we were informed recently that in some places, dietitians were spending two or three hours on such work and were queried whether veterinary personnel could assist in or perform such inspection. It is your prerogative as commanding officer to utilize veterinary personnel on such work at the hospital. I believe that one or two of the hospitals are doing this. There are no veterinary personnel at Beaumont, but veterinary technicians from the station are doing the work. It's also being done at several posts and stations. The only request we make is that in performing such work, it does not interfere with the primary mission of inspecting foods of animal origin, particularly if the officer or enlisted man is doing inspection work at class 3 or point of origin. At most

general hospitals the latter would not be the case, as a meat and dairy technician is assigned the hospital to accomplish destination, storage and inspection prior to issue.

DISCUSSION

COLONEL ROBINSON: General Bliss, Colonel Doan has given us the rest of the morning for discussion and I'm sure it will be all right with you.

GENERAL BLISS: Yes, this can be taken up with discussion now by anyone or everyone on the personnel problems. I thought perhaps I could inject some kind of a note into this about statistical personnel. I am perfectly aware that hospitals are not run by statistics and these figures that I'm giving you now have to do with operating personnel in general hospitals covering a period from January to November 1947. It has been a very interesting experience going down from some 200,000 patients in our hospitals to 16,000 now in our general hospitals, and following the curve of personnel. As you know, we are checked very carefully by the Manpower Board, by the Bureau of the Budget, and by all the agencies in the Department of the Army. Our calculations are made on the total Army strength. The Army strength is much below what we contemplated it would be. The health of the Army happens to be the best that it ever has been in the history of the Army. We have fewer patients. However, we get some figures that are interesting anyway and sort of mitigate terrific arguments by us for getting more personnel at times. I'm always willing and in favor of personnel when we need them. We have this analyzed, by personnel per hundred authorized beds, personnel per hundred patients remaining, personnel per hundred beds occupied. The types of personnel are male officers, female officers, enlisted personnel, and civilians. We authorized a certain number of beds. The beds have gone down in authorization from 35,000 in January 1947 to 25,000. At the beginning of the year we had 75.5 per cent personnel per hundred authorized beds. At the end of November, we had 98.4 percent per authorized beds. This probably doesn't pertain to any one hospital here as these are statistics from all general hospitals. We had an increase of 30 per cent in the number of personnel per beds. In personnel furnished by The Surgeon General, we had 60.2 per cent per hundred authorized beds at the beginning of the war. We now have 74 per cent, an increase of 23 per cent. It has been a big complaint all the way through that the Armies were not furnishing their number. They start out with 15 per one hundred beds at the beginning of the year and end up with 24 which is an increase of 60 per cent. With male officers we started out with 6.6 and now have 9.3 an increase of 60 per cent. The female officers decreased; they started with 8 per hundred beds and ended up with 7.9. The enlisted personnel started at 37 and ended at 42 an increase of 14 per cent. Civilians, and I realize that there is a difference between graded and ungraded civilians, I realize all the implications there are with reference to all these things, started out at 24 per hundred beds and ended up at 39. Now to analyze that further in personnel per hundred patients remaining I'm just

giving the increases, if you will, in total they came up from 82.7 people per hundred patients remaining, to 139.8 an increase of 69 per cent. Those furnished by The Surgeon General increased 59.5 per cent. Those furnished by the Armies increased 106.5 per cent. They started out with 16.8 people per hundred patients remaining and went up to 34.7, an increase of 106.5 per cent. The officers increased by 81.9 percent; female officers for each 100 patients remaining were increased in the year by 29.9 per cent; enlisted personnel 47.4 per cent and civilians 112.7 per cent. The personnel per 100 beds occupied. These are comparable figures that they use in all the government services. Some of them figured the beds occupied and some of them patients remaining and some of them total beds. We have them all. At the beginning of the year we had 26,886 patients in occupied beds and at the end of November 13,765 in occupied beds. The percentage increase in people per 100 beds occupied was all the way through 82 per cent, 72 per cent, 122 per cent, male officers 97 per cent increase, female officers 39 per cent, enlisted personnel 59 per cent and civilians 129 per cent. So at least statistically we were better off. According to these statistics, the standards of many of our general hospitals would appear to have been improved as far as numbers are concerned. I hope that it will all be brought out in the discussion as to why you are short and if you are short all right, but it has actually increased that number since the first of January until the last of November according to very carefully analyzed and detailed statistics. I know that some of the big cuts in personnel came after November and later figures may show a different story, but at least through November the figures are encouraging. I'd like to say one thing about the insignia that was rather interesting to me. It came up two or three times during the war and since the war. I believe that it is impossible to get an insignia which is approved by anyone except one person. I've never seen any two people agree on an insignia. I hope the new one will be nice.

COLONEL ROBINSON: I have a few notes handed to me to announce. First, the Army Surgeons should note that the public relation officers throughout the Army are being notified of the Army Nurse needs. In other words, they will be told that 25,000 nurses will be granted commissions in the officers' reserve corps. Four thousand of those will be permitted immediate active duty in Army general hospitals. They will publicize the fact. They will very likely come to your surgeons in your stations for further information. Anything that you can give them will be acceptable. Also, another note is to the effect that General Dalhquist is very much interested that all of those officers who are eligible for promotion get promoted promptly. Please get their recommendations in in the ordinary way. That includes all corps of the Medical Department, and the criteria are all published. We would like now for our procurement program to be thoroughly criticized by you. I know Colonel Gorby wants to say something.

COLONEL GORBY: General Bliss, I would like to present the problem of the Army surgeon from my standpoint which I believe is equally applicable to the other Army surgeons on an area basis. I've had a little personnel study made in my Sixth Army Area and in trying to invision the requirements at a certain date, the material I have to work with, and then listening to these stories I am a little pessimistic. We have to get some answers. As an example, I would just like to cite one or two things---I go down in medical corps officers from an assigned 234 on an authorized 205 at the present time to 133 following the April exodus and down later in the year to 94. Of those, 25 are assigned to T/O units. And of the remainder, some 15 are at present on duty supporting class II installations which are isolated, and which have to be covered. When you subtract the 20 which are with the 2nd Division and the Engineers Special Brigade you don't have much left for your own requirements. Of those that remain, I don't have qualified personnel to cover what I consider the primary mission of the Medical Department---service to the line in its field operations and training. And this takes no cognizance of the UMT program which I think we all have to consider.

We are exploring contract dentists which I hope they will give us; exploring contract surgeons as to their probability, but we need some help---$150 for a part-time contract surgeon or a little more for day-time contract surgeons does not solve our situation now with the present price of things outside. I think that some legislation should be inaugurated to change that so we can offer them something and get qualified personnel. I think that we can make out in certain of our station hospitals where we have a residential responsibility if we are given some qualified personnel to head up the major services. That is, a man that can serve as the chief of medicine, the chief of surgery in say a 400-bed hospital. One that we can depend on in evaluating the officers, leading these ASTP's, etc., contacting them and interesting them in the Army. We have quite a few other officers at Riggs Field and I think contact with them or competent personnel of that nature is important. I have no other comment. I would like to assure you that no one is any more interested than I am in seeing that we get this training program completed, but as I listened to our program here, which is fine, I can't see where we are going to get the personnel to cover the Army requirements and I'm sure that this applies equally to all the other Armies.

COLONEL ROBINSON: With regard to Colonel Gorby's question about hiring civilian physicians, I stated in my original talk that that legislation has gone to the Department of the Army, and that it is expected it will be proposed at this Congress. As to the other question of Colonel Gorby's specific needs in the Sixth Army I

think that it would be much better for that to be discussed in our Division with my officers. I'd still like to have my procurement program torn to pieces.

COLONEL WILLIAMS: I have one question on my mind reference to procurement of personnel. We are all aware, and have been for some time, that we are progressively losing officers. As we get vacancies, we will requisition on this office for replacements. You will be unable to fill all those requisitions. I request that when you do have a replacement that you teletype us the necessary information on the individual and let us decide where he will be assigned. The picture will be changing so constantly that only the Army surgeon will be in a position to know where the need is most acute and where the man should go.

COLONEL ROBINSON: Colonel Bramlitt will you make a note of that information for further use.

COLONEL BLESSE: I think we ought to consider a bit more the use of the Medical Service Corps. In the past, we never have given that proper consideration, yet that is the one place where we can hope to get substitutes for the medical officers who are not on purely professional status. It seems to me, as we go over our T/O's, we can so frequently substitute if we can get the right kind of a man. We had difficulty with the old administrative corps because they were taken in in a haphazard manner. We had some good men; we got a lot of poor ones. Then there was the proper assignment and training for that assignment before the man went out. You've all seen them come into a general hospital for instance, and maybe have the post exchange thrown at them or various things. I've seen some have three or four jobs thrown at them immediately without any training whatsoever. We had some MSC officers that we threw in with the basic course at Carlisle at that time, if they were convenient in that general vicinity, and so on. We didn't give those people the proper chance. I think that we can, with better selection now and with still more emphasis on good selection, study the qualifications of these men. I think we will find that there are some that will definitely show up badly if you put them in an office when they are entirely qualified in a different field. Others again will show a special line. I think training should be set up to make them possible substitutes in some of these places; I'm referring to the field of preventive medicine. There probably are a great many installations that have to do with water purification, waste disposal and everything else. There are many of these jobs that could be handled by trained MSC officers. By trained I don't mean the courses--which there seems such a tendency to put out today--ten days, thirty days and so on--most of them aren't worth the time, the travel, and the expense. I believe, however, if you would put these selected men in training in preventive medicine, they could qualify.

We plan to do that in battalions especially by giving a battalion surgeon's course. We put them in during the war and where they were properly selected, it worked out very well. In some instances it didn't, because they hadn't been properly selected and trained. There are other conditions--the courses must be of sufficient length, duration, and enough thought put into them to qualify the man for the job.

I think as we look over the various T/O's we can still find a good many places to save medical officers. If we do that, our problem of course will be the emergency problem. I don't know whether we will have time to work up this training to a point where a man will qualify. In peace time, I don't see why there should be any problems. It is possible that training could be worked up so that in an emergency we could still qualify a sufficient number of MSC officers to take over a great many of these other jobs on which we are not using medical officers.

COLONEL ROBINSON: I'm certain the Training Division has representatives here who will take cognizance of that.

GENERAL DENIT: I've got a lot to say but I'm not going to say it, but I do want to say that I'm opposed to any idea of subsidizing anybody. That has been studied by me for over a year and one-half and for two years I have been thinking about it in a larger sense. I hope we don't go along with the Navy with any idea of subsidizing the individual. In the first place, medical schools can't take them; they can't take anybody else, but you all know my views on that. I m not sure, but I think this contract surgeon business at $150 a month was started back in the Spanish American War and it is the most ridiculous thing I've ever heard of in my life--$150 a month! I think that whole thing ought to be wiped out. I think that law and regulation, I think the whole thing ought to be wiped out. It's merely an insult.

Now, this thing that Colonel Williams has been talking about has caused me serious concern, so much so, that I wrote a letter the other day to every one of my hospital commanders and told them that the show must go on, whether Helen Hayes played the leading part or not. Somebody has got to take her place. Therefore, if Helen can't act in the show, they must take these youngsters and start to train them right this minute to take their place. We'll have to go back to the days where boys were told that they must understudy some one for EENT and some one for this, etc. We have no idea in the First Army of dissipating our forces. We expect and hope to keep one or two station hospitals at the highest level possible.

We are going to put on this spring a command post exercise on which we are making studies now with the Air Corps. We are

going to utilize cub planes and motor boats for evacuation of our patients around Jay, you know we are on an island there, and sometimes you can't get out because of fogs. I've talked it over with, not the Air Corps, but the officers that fly. The flying officers that are on that field there and we are going to put on these exercises to see if we can bring patients into Jay and over to Totten, etc., by plane for necessary work. The question of whether we can have dependents on the plane has come up and we have decided that dependents were going to be called an emergency. If they need surgery, it is an emergency. That's how seriously we regard the situation. Now I just want to say one more thing--I certainly don't want to see anybody subsidized.

COLONEL ROBINSON: General Denit, I would like to ask you a question. Do you consider commissioning a resident in his civilian residency and allowing him to stay there as a subsidization?

GENERAL DENIT: No sir. I think that is a fine thing. There is no more reason why we shouldn't do that than why a boy should graduate from West Point and go to the University of Virginia to study law. I'm delighted with the idea and I'm not criticizing any of your program. The thought I am criticizing is any idea of taking up boys out of high school and subsidizing them to nine years of school; then you have an indentured slave. It's the same old indenture. We have found out after long experiences that this indenture problem is no good. We don't want anyone in the Army except the people that want to come in.

GENERAL QUADE: I have a question here with reference to this Circular 79 on the separation of officers by 30 April. There is no reference made to patients. What are we going to do for example with a nurse patient who is in the hospital awaiting disposition?

COLONEL ROBINSON: We have proposed a change in that circular already and I wonder if any of my division--"Is Major Mackin here--did you write that?"

MAJOR MACKIN: Yes sir, but the Adjutant General is sending out a radiogram that will be back to us today for concurrence which will allow the commissioning of all people in the detachment of patients in the "Honorary Reserve." They will be retained on active duty in their AUS status until they have completed their hospitalization, at which time, if they are physically qualified, they will be commissioned in the active Reserve, if not they will not be commissioned in the Reserve.

GENERAL QUADE: Will that apply to nurses?

MAJOR MACKIN: Yes sir. The matter of nurse pay, however, after

1 July will, I imagine, have to be covered by a separate directive to finance officers to assure their payment, but we will follow up on that too, sir.

GENERAL QUADE: The other question I have is in reference to the Secretary of the Army's orders which seems to provide overtime on the regular basis.

MAJOR MACKIN: We'll have to take that up with civilian personnel.

GENERAL QUADE: One other statement that was made by Colonel Maley that I didn't understand. She made some reference to not being able to use a reserve officer in a grade of Major which would call her back as a grade of Captain. I don't understand that.

COLONEL ROBINSON: Will you talk to the Nursing Division about that?

COLONEL RUDOLPH: I have no particular comments about the procurement program. Of course, we all realize the urgent necessity for getting people and when I look at my loss figures here for the past two months and a half, it's very startling. The figures are, of course, the same as those of the Sixth Army and the Fourth Army. Here's one matter of personnel though that I would like to mention, and that is the policy of using hospital beds in station hospitals as a yard stick for the allotment of personnel. I find that 50 to even 75 per cent more of our medical effort on our stations is exclusive of the people occupying hospital beds and I hope that something can be done about it.

COLONEL ROBINSON: Colonel Thomas would you like to make a remark?

COLONEL THOMAS: I have been learning a lot about these problems and I must say that I think that I have been influenced by my trips around to take a much more cheerful attitude than the talks this morning. I think perhaps I shouldn't say that, because I think everybody seems to be taking it as seriously as they possibly can, and there seems to be no danger that anybody will overlook the gravity of the situation. However, I do think that it's worth saying that the bottom has been passed and that there is a very great interest in Army medical careers. I think the ASTP boys are taking a different attitude and it took a little while to get over the Niagara Falls of the people rushing away from the Army, the medical officers trying to get back home. Now that's over and I honestly believe that the tough spot has been passed. Of course, that doesn't take care of this immediate critical period of two years that Colonel Robinson is so much worried about, but I do feel more cheerful about it because I think the Army Medical Corps is in perfectly wonderful shape. I think that the Staff--everybody that I talked to up there is interested. They realize

these personnel problems were foreseen in The Surgeon General's Office back in 1943 and 1944, and the requests for action at that time were denied the Medical Department by the Army. Now their attitude is very different.

The only thing that I really want to say is that I believe personal approach in procurement of medical officers is very important. However, how we can get the people to approach these doctors--civilian doctors--with our present shortage, is of course the whole catch. We would all like to go out and spend our time talking to people who are interested. There are certain ways, and that is being thought of very carefully. I believe that is the thing that I would like to leave with all the visiting officers which is their opportunity to do the final pair up which is the personal approach.

GENERAL BLISS: I want to say just a word. I hope the Personnel Division is doing that and that it will show up in time. I have found in my traveling around that the medical officer wants to know what you have to offer him, definitely and specifically. We have gone out now in Europe, ETO, and we have heard that they need 143 key men, and they say where these key men will be assigned and what they will do. They also told us that the key men which we will send over can take their families with them on the boat and so forth. I hope that personnel is going on that basis in the United States as well as in ETO. We are approaching every single doctor in the country. Colonel Amspacker didn't mention that. He has written to the deans of every medical school and every hospital and all of the consultants to approach these doctors all over the country--offer them definitely something that they can do in Germany at the present time for a year. I am certain that, properly approached, a great number of these ASTP men who are now being discharged, who could be promoted to Major after two years's service and are told that they would go to a specific place for a year, would go there.

As far as the contract surgeon, of course that's actually obsolete, but personnel, Civilian Personnel, has told me that we can, at the present time, hire doctors under Civil Service on full or part time basis. The administrative procedure is difficult but it can be done if you know someone who wants to come. If you can get him to come in, the arrangements can be made that they will come on at a specific salary for as long as you want them--about $50 a day.

GENERAL ARMSTRONG: I think you all know Harold Glattly. Hal is a medical officer on detail with the Inspector General's Department. He came down the other day and asked me if I would ask the hospital commanders if they would be interested in selecting from their staff a medical service corps officer, who, perhaps, they are now utilizing

as a hospital inspector, and request that he be detailed to the Inspector General's Department. It is the opinion of The Inspector General officers with whom he has talked up there that it would increase the stature, so to speak, of this officer, would give him a direct channel to The Inspector General. He's still your man. It seems to me on the face of it, that it might be a good deal more valuable to you than just to designate him in a hospital order. Think about that during the lunch hour and I'm going to ask for a show of hands before we break up this afternoon.

GENERAL WILLIS: I would like to interrupt this meeting a minute just to say that at the present time with the 23 or 26 whatever it is that we have as PMS and T's for the medical schools, we have, generally speaking, the cream of our crop of officers on that duty. Those that I know are tops--they are the very best that we have. Certainly those that went from Brooke Army Medical Center are just the tops of our officers. I think more publicity might be obtained through the American Medical Association and certainly through the secretary, who is one of us. I also think there should be perhaps a more liberal policy of authorizing and ordering officers and even the younger officers on the professional service, at government expense, to attend the medical conventions. I think there they will get the contacts and can sell a great deal for the Medical Department. Of course, the promptness in processing of those applications that do come in is of inestimable value. In connection with the attending of these conventions, societies and so forth, to get as many of them to present papers as possible, I think that will be good for us.

I was talking with an officer just recently, at noontime, and it seems that there is a possibility of some of the better ones of these ASTP's being promoted. If we can promote some of those who are going out next April or March to a majority, that gives them a pretty good increase in pay. To do that, they will have to volunteer for a year's service and then be eligible for the $100 a month extra. Some of them will want to stay. Also I would like finally to give the experience that we have had in bringing the Medical Corps as a career to the attention of the young officer. If you get them all in a room like we all are here, and talk to them about coming into the Army, you don't get any response. It's just like a man getting religion. It's something of his own, and he doesn't want other people to be talking to him about it until he has made up his mind. We got nowhere when we talked en masse so we put a notice on the bulletin board that any officer interested in the Regular Army could contact by phone, give him a phone number, plan that there would be an officer to talk to him privately. The officers that talked to him privately was Colonel Streit, General Martin, the assistant commandant of the school, and myself, and we got a tremendous response to that. They would come up for interviews and we got a good many applications from that way of handling.

GENERAL ARMSTRONG: Thank you very much. Those are fine suggestions. I hope some of your crew will take them down. I saw Hal Thomas writing back there. Did you get them all? I think they are fine.

COLONEL GENTZKOW: Speaking of the PMS and T's at Valley Forge, we have already contacted the three at the schools in Philadelphia where there are PMS and T's and have arranged for a clinical afternoon, a visit to the hospital, dinner at the officers' club for the junior class now engaged in ROTC some time in March or April as soon as the weather opens up. I throw that out as a little advertising slant.

S. HOSPITAL ADMINISTRATION PROBLEMS.....Colonel William D. Graham
Colonel Achilles L. Tynes
Major Helen C. Burns

COLONEL GRAHAM: General Armstrong and gentlemen, I have placed on each army surgeon's tablet a request for specific information about station hospitals. A copy of that has also been put on General Grow's place and I am urgently in need of getting this information so that I can proceed with studies for the Hawley Committee and for a Congressional investigation and study. I would like to have this as soon as you can possibly get it together for me as I need it on the 26th of January. If this is too big a job, please give it to me as soon after that as possible but let me know when I may expect it from you. I realize that asking you for this information which should be secured through other channels is requesting a favor, but it is one which is of the utmost importance to the Medical Department and I feel sure that you can contact me personally with the information.

WARD SERVICE CHARGES - DEPENDENT CARE

The care that is rendered to dependents by the Army Medical Department is considered to be legally authorized by the phraseology of the Act of 5 July 1884 (10 USC, Section 96), the pertinent portion of which reads, "medical officers of the Army and contract surgeons shall, wherever practicable, attend the families of officers and soldiers free of charge." There have been many rulings which have supported the rendition of care to dependents provided that facilities are considered by the hospital commander to be available. Military personnel are not entitled to the medical care of their dependents at the direct expense of appropriated funds, but their dependents may be given such care, and only such care, as is available at Army medical installations. It has always been the policy of The Surgeon General of the Army to render as complete medical service to military personnel and their dependents as has been possible. Prior to the war, the wording of the Medical and Hospital Department appropriation directed that the monies authorized by the Congress for the medical care of the Army were appropriated, "for the medical care of officers and soldiers," and this wording had been identical for many years. It was, therefore, considered proper and was construed to be legal to make additional charges for various expensive medicines and for blood used for transfusion in the treatment of dependents, and charges were also authorized in many medical installations, which when deposited in the hospital fund, made available to the hospital commander additional monies with which to defray the salaries of a few maids or female attendants for the care of dependents. In 1944 the wording of the M and HD appropriation was changed to read so that the annual military appropriations act provided funds for, "medical care and treatment of patients when entitled thereto by law, regulation or contract." Since by derivation from the law of 1884, medical care could legally be given dependents when

practicable, and since by recent law monies are appropriated for the care of such patients, the collection of ward service charges at the present time would be an operation specifically prohibited, both by presidential directive and congressional action. Both the President and the Congress have indicated that it is illegal to supplement appropriated monies to perform functions for which appropriated monies have been made available. The Medical Department budget is established on statistical data derived from experience as to the number of patients who will require medical care. Dependents are included in the total, and when the various factors are applied to set up the budget, sufficient money is included in the budget to provide for the care of dependents. In a similar way, beds authorized for operation meet a total that includes the requirement for dependents. In spite of the frequent reductions in personnel made available to general hospital commanders and to station surgeons, the number must either be considered to be adequate for the care of all patients, or dependent care must be curtailed. The entire problem of dependent care might seem to be capable of solution were the Army to request legislative action similar to that recently obtained by the Navy. However, when the Navy law is analyzed, it does not afford as great potentiality, either for the care of the dependent or for freedom of action by the Medical Department of the Navy, as existing policy and law offer to the Army.

There are at present a number of plans in effect in various places that directly or indirectly embody the collection of ward service charges from dependents. Some of these have been established because the allotment of personnel to operate the hospital has been so reduced that dependents' wards cannot be staffed, and the post commander has, notwithstanding this shortage, directed the surgeon to render complete care to dependents and has approved or directed a per diem charge. In other instances, dependents have organized themselves into a type of "blue cross" organization, and by paying dues have guaranteed that maids and female attendants can be employed to care for them in the post hospital when they become ill. Undoubtedly, by the variations inherent in these various systems, complaints will be made to The Inspector General by individuals who do not desire to participate or who refuse to pay. The Inspector General will again indicate that procedures of this type are improper and must be immediately discontinued, as was done in 1944. The only solution I can suggest under the present situation is that army surgeons explain the background of dependent care to the army commanders and then attempt to insure that all funds of the Medical and Hospital Department appropriation that are allotted to the army commanders are suballotted to those stations that are so in need of them. The Army Surgeon should then make every effort to guarantee to the station surgeons that personnel authorization in sufficient number, both civilian and military, will be given to operate the station hospital. Following this, it is essential that the personnel actually be made

available to fill the allocations.

CARE OF NAVY DEPENDENTS

Since the passage of the Unification Bill, numerous problems have arisen with respect to the medical care of members and of dependents of the three armed forces, and a tremendous amount of pressure is being applied by congressmen and others for an immediate solution. This has been particularly true in the case of the authorization to dependents of the Navy for admission to Army hospitals. The entire problem is being referred to the Secretary of Defense by the secretaries of the three services with recommendation for mutual eligibility of the dependents of all services. It appears reasonable that the matter will be referred to the Hawley Committee for consideration.

As you know, the Army has for many years rendered courtesy type medical care to Naval dependents in many instances. This has been a great contribution by the Army in the past in view of the fact that at that time the Navy could not hospitalize its dependents.

Immediately before the appointment of the Hawley Committee, informal approval had been given for the extension of dependent privileges wherever practicable to the dependents of the Navy and at the same charges, namely, subsistence only, but formulation of the approval appeared to be precluded by the establishment of this committee. No definite decision can, therefore, be given at this time. It is certainly in keeping with our past policy that we should make every effort to give as much care as possible to dependents of Navy personnel, if facilities can possibly be construed to be available, and when such care involves hospitalization and can be given to Army dependents, it should be given. This is being carried out of necessity in medical installations of all services in isolated areas, such as the overseas theaters, and in certain places in the U.S. It is obvious that with the personnel situation as it is, there may have to be curtailment of the entire dependent care program, but while possible it should be given under the provisions of AR 40-590, construing dependents to include those of the Navy as well as those of the Army until a final decision has been approved by Mr. Forrestal.

SICK LEAVE

Discounting the statistics that result from the large amount of sick leave given before and during the Christmas season, figures available in the office indicate that approximately one patient out of every five on the rolls of the general hospitals is absent from the hospital on sick leave. There are about 2,000 veterans in these hospitals and 2,500 dependents and other civilians. Sick leave is not granted to patients in these categories. Therefore, when

the total patients remaining are adjusted by subtraction of veterans and the dependents, it appears that one out of every three military patients has been granted sick leave, and this figure is maintained throughout the year except for the tremendous increase at the Christmas season.

Further analysis of the data indicates that only three percent of patients in station hospitals are granted sick leave, but of the station hospital-type patients treated in general hospitals, approximately fifteen percent are given sick leave.

Professionally indicated sick leave has been, and must continue to remain, a prerogative of the Medical Corps. It is only by the careful screening of all requests for sick leave on a professional basis that we can hope to retain this authority. During the war, both because beds were needed and because it was essential for his morale, the patient was allowed to spend time on sick leave, even though it might prolong his ultimate disposition. It is the current practice to permit patients who are awaiting administrative action on retiring boards to be absent from the hospital on sick leave because there is no other administrative category, such as administrative leave, in which they can be placed. Because of the interpretation of the wording of the Armed Forces Leave Act, as amended, it is highly probable that the granting of sick leave to these individuals will very shortly be prohibited, and it will be required that these patients utilize their accumulated leave during the waiting period. This action has thus far been forestalled by this office by the representation that these patients would refuse to take accumulated leave for this purpose and would remain present in the hospital with the inevitable results of violation of regulations and disciplinary problems. However, it is immediately apparent to anyone receiving Medical Department statistical reports that we are granting sick leave to approximately 4,000 out of 17,000 patients, and this large number comes up for constant justification. We urgently recommend, therefore, that requests for sick leave that in any way prolong final disposition and are not thoroughly based on professional requirements be disapproved.

HOSPITAL FOOD SERVICE

MAJOR BURNS: After the speech just presented by Colonel Collins, I'm afraid my talk will seem a little dull, but to us Hospital Food Service is important. I should like to give you a little of the thinking that we are doing here in the office and that we are trying to get out to the dietitians. The aim of the Hospital Food Service is to provide nourishing and appetizing food for the patients, personnel, and the staff of an Army hospital. The purpose of the Hospital Food Service is to accomplish this work with efficiency by means of well thought out plans of operation and the use of personnel and

material. All of our hospitals haven't as yet accomplished the organization set-up we would like to see--that is, one which will work more or less like clockwork. There should be a maximum economy through firmly established administration methods of control in planning and use of materials. Then we need to have organized training. We are progressing toward these goals, and we hope with specialized personnel that we will soon reach them. Everyone of us agree that the food service suffered more with the change of personnel than any other department. During the war most of the hospitals had trained civilians. Then we were told that this group had to go and their places would be filled by enlisted men. We were rather happy to see it, because I think we all like our GI cooks. However, we found the men coming in were untrained youngsters. It was necessary to start from scratch and train them as best we could. In some hospitals they were just sort of dumped in on the department; therefore, the organization that had been set up broke down. That group has gradually been replaced by civilians, and the organizations are on the upward trend.

You probably wonder what your chief dietitians have been gaining in the symposiums and institutes that they have been attending, when you probably felt that it would be much better if they had stayed at the hospital where their assistance was needed. I think if they got nothing else from attending those meetings they did get away from their jobs long enough to see the department as a unit. Too many of them had been so close to the job itself that they hadn't been able to see the over-all problems. They also exchanged ideas with other chief dietitians--which is always good. Stress was laid on the need of having a definite plan of operation, fixing responsibility through established lines of authority, systematizing the work, and establishing operating rules and regulations. In order to accomplish this the dietitian will have to have certain "tools," and we are trying here in the office to help her out with these. It is realized that in the hospital the dietitian doesn't have time to do much of this detail work. A film strip, which will be entitled "Training Hospital Food Service Personnel," is now under way. This film strip we expect will be broken down into four parts. The first part will be on "Indoctrination of Personnel Assigned to the Hospital Food Service." The second part will be on "The Operation, Care, and Maintenance of Hospital Food Service Equipment." We realize that much of the equipment is the Engineers' responsibility; but yet we're using it, and we have to get the maximum use out of it. By instructing our personnel, I think we will accomplish this. The third part concerns "Serving of Food to Patients." That will take in the dining room and the wards. The fourth part concerns "The Preparation of Special Diet Food." We haven't cleared all of these with The Quartermaster and other services, so there may have to be some changes.

We need an active training program for all of our employees,

particularly now with so many new ones being employed. During the war we did have a good training program set up. With the large number of replacements being made, it has been necessary to do most of the training on the job. This is good training, but time should be taken to give reason for instructions in order to gain the desired results. Dishwashing is a good example of that. One can go in time and time again and tell the men not to stack the dishes, but invariably the bowls, cups, plates, and everything else are in one box. It takes time to stop and show them that you have a reason for the separation of dishes and if done properly it will not be necessary to send them back the second time. The results are usually better. It is believed the film mentioned above can be used for training new personnel and refreshing the memories of our old personnel.

We appreciate the fact that the dietitians have been given the opportunity to discuss their problems with the commanding officers or the executive officers. This is one of the things that we ran into so much in making inspections. The dietitian didn't feel that she could go up to the front office with her problems. We, who have been in the Army, knew that that was not so, but there were many coming in who weren't acquainted with the ways of the Army. These conferences have been most helpful.

You probably wonder about the menus that are being sent in--why we have them. We like to have them in case any questions come up regarding the items used. And we are constantly getting questions. That brings up reports that we are asking for. We will try to keep these to a minimum, as we know that you have many other problems to deal with. In order to make intelligent studies of the requirements of the Hospital Food Service Department, it is necessary to know the number of main kitchens in operation. No two of our hospitals are the same. The number of diet kitchens serviced is also required. It is not possible to assign one dietitian to one hundred patients; because, while in one hospital the proportion of one to one hundred would be fine, in another, where the setup is quite different, it might take one to seventy-five, or in still another you could probably use one to one hundred and fifty. Much depends on the physical set-up.

Too often we are told by other services that there is no difference in the feeding of troops and patients. We know there is, but some tangible information must be made available to show this difference. Charts for the food service set-up of all general hospitals have been made; and, with very little information from time to time, it should not be too difficult to keep them up to date. I understand that some of the hospitals have a very long and lengthy report to make out, particularly those in the Sixth Army. It so happens that this form is one that the Sixth Army Headquarters sent out. The Food Service Section in the Office of The Quartermaster General has been working on one. It is understood that when it is

put into use, The Surgeon General will send out his own instructions as to its use and the information desired. There is much of it that is of no value to us, and it was difficult to get this point across. Again, other services fail to realize the difference in the food service in the hospital and the food service in the field. Gradually, we are getting very good cooperation from the market centers. It was necessary to go out--and thanks to the commanding officers for their support--and show the market center personnel just what was needed in the hospitals. There will be other problems on which your cooperation will be needed. We know there are still some weak points in our food service program, but we shall continue to work until it is the very best. We are always willing to help, and it is hoped that any problems concerning which this office can give assistance will be stated to us.

CENTRAL HOSPITAL FUND PROJECTS

COLONEL TYNES: General Armstrong, gentlemen, I am sure each of the hospital commanders here today is wondering what has become of his "letter to Santa Claus" requesting free projects to be financed from Central Surplus Hospital Funds, as outlined in W.D. Memo. 40-590-10. You also were probably disappointed when Christmas came around and you found your stockings still empty.

You will recall that all projects were to be submitted to The Surgeon General prior to September 15. By request from a great many of the hospitals, this was extended, first to October 15, and later, to November 15. A number of hospitals still have not submitted projects, but are no longer considered eligible under this memorandum.

This office did not publish the amount of surplus central hospital funds available under this program, but rather directed that, in accordance with the memorandum from the War Department, the program be limited to approximately $60 per authorized bed for each station and Air Corps hospital, and $100 per bed for general hospitals.

It was decided that, in view of the uncertainty of the cost of labor and materials, it would be wise to withhold approximately 20 percent of the total funds available to serve as a contingency fund to individual projects that might cost more than the estimated amount. This, in view of the fact that no additional funds will be made available to the project. Accordingly, a sum of $3,200,000 was declared available to finance the individual approved projects in this program.

In spite of instructions to the contrary, the total cost of projects submitted amounts to over $11,000,000.

SS&P directed that the entire program be consolidated and submitted in such a form that it could be approved with available funds.

The task of consolidating this program and reducing it from $11,000,000 to a little over $3,200,000 without hurting any individual hospital or showing favoritism has been tedious and painstaking. The program from one hospital only, and that from an overseas theater, was divorced from the program and sent up to SS&P separately last fall. This project required approximately sixty days for clearance. Because of this fact we worked directly and closely with SS&P in summarizing and clearing the rest of the program in order that it could be presented in such a form that its clearance would be only a matter of form.

Many widely divergent cost estimates were submitted by different hospitals on exactly the same items. These had to be rationalized before SS&P would give blanket approval to the program. For example, the cost estimate for the diet kitchen renovations, including only cost of the stainless steel dish table and installation of free issue equipment supplied by the Government, ranged from a low of $207 to $3,500.for general hospitals, and as high as $5,200 for station hospitals. It was found that the most reliable bid for this item of equipment based on acceptable standards, was made by S. Blickman, Inc. Blickman's cost for the dish table amounted to $1,100 as an average. Installation of all free issue equipment amounted, as an average, to an additional 700, including $200 overhead for the Corps of Engineers. Accordingly, since The Surgeon General desires that the renovation of diet kitchens be given a high priority in this program, a fixed amount of $1,800 per diet kitchen is being set aside for each hospital where such renovations have been requested.

In view of the above factors, please bear with us and understand first, the necessity for the delay in processing this program in accordance with criteria set up by SS&P, and second, realize that when a Christmas program is cut from $11,000,000 to slightly over $3,200,000, the presents will not be quite as many or just exactly in accordance with your letter to Santa Claus.

In spite of this, however, each of you can hope to get the projects that you have counted on most, and if they are financed in accordance with your original estimates you may expect additional items from surplus funds that were originally withheld as a contingency fund.

SS&P, with whom we have worked very closely, informs me that there need be little or no delay in this program in view of the careful screening already given. Each of you will be advised shortly, through means of a form letter of the projects that have been approved, giving instructions for future action on your part. Where W.D.Form 5-25 has already been completed in full, it will be necessary only to inform this office that no change has been made either in the estimated cost or plan for the project before authorization is given to proceed. If W.D. Form 5-25 and supporting plans and specifications

have not been previously presented, these must be executed in accordance with original A.D. Memo 40-590-10.

In closing, let me again repeat that your program, as presented, has been consolidated and reduced from $11,000,000 to slightly over $3,200,000. A 20 percent contingency fund has been withheld in this office to take care of unexpected emergencies and cost increases. All of these funds will eventually be expended for some of the items now included in the original program.

T. INFLUENZA VACCINATION.....Colonel Tom F. Whayne

General Armstrong and gentlemen, I want to take just a very few minutes to advise you of the influenza situation. I know that many of you must have had some criticism of the supply of influenza vaccine. I want to tell you the reasons back of that and ask your cooperation in certain plans we have for further study of the vaccine. Now as most of you know, we were advised by the Army Epidemiological Board at its annual meeting last April to include in the vaccine the FM-1 variant of the A strain. This is the strain that was isolated at the Army Medical School from specimens from Fort Monmouth--hence the FM-1. In starting on the program as late as April, and considering the fact that the contracts had to be let and that production of egg-type vaccines throughout the summer months is difficult, the manufacturing company had great difficulty in adapting this new strain to and obtaining good growth in eggs. We thought that it had been thoroughly adapted to eggs. It had to be taken out of eggs, run through mouse brain passages, and back into eggs. They actually were not in production until the end of the summer. We had hoped to have the vaccine ready to go by that time. They have continued to have some technical difficulties from time to time, and therefore we were delayed in the distribution of the vaccine until the end of December. I understand that some of you have received your vaccine only recently. That is the background of the slowness with which the vaccine has reached you. In addition to that, the quantity of vaccine the Lederle people were able to produce, much as they had thought they would be able to give us any quantity that we wanted, by reason of the technical difficulties noted, was greatly reduced. Hence we had to cut the requisitions for vaccine by 25 percent. We did feel, however, that there had been some over-requisitioning, and that most of you would be able to vaccinate adequately your personnel under these circumstances. If there is any shortage of vaccine, go ahead and re-requisition your actual needs, because we do have vaccine in the depot at the present time. Back orders also will be filled. However, I ask your cooperation in looking over the requisitions for vaccine, and make them as practical and as near to your actual needs as possible. There are reasons to believe that the FM-1 component of the vaccine may not be as well worked out as we had hoped. We have asked the Supply Division to limit the contract on the vaccine so that we will not have any great amount left over next year.

As to the nature of the vaccine itself, we fully realize that with our present stage of knowledge, we do not know enough about it. We have in it the B strain and variants of the A strain. As our experience last year demonstrated, we may at any time encounter another strain or other strains for which these components are not protective. As a matter of fact, the 1946 vaccine did not afford protection against the type of influenze we had last year due to the absence of the FM-1 strain. We know full well that that could

happen again, and so we are constantly searching for additional strains or, better still, for an antigenically broad strain that could offer protection for the several of the known strains and those that have not yet been recognized. In order to set up an evaluation program at this time, we have had the assistance of the Army Epidemiological Board again, and, under the general direction of Dr. Thomas Francis of the University of Michigan and Dr. Jonas Salk of the University of Pittsburgh, we have set in motion a program for the evaluation of the influenza vaccine. We have set up at Fort Dix separate groups in which we are observing the effects of the old type vaccine, which does not have the FM-1 component and the new type vaccine. By cooperation with the Navy we have observations going on at the Quantico Marine Barracks with an unvaccinated group in comparison with Fort Belvoir, also a school with almost the same population, which is a vaccinated group. This is only the beginning of an evaluation study that we anticipate will take several years. We hope next year to obtain permission to conduct observations on vaccinated and unvaccinated groups in the Army. We may be asking assistance from some of you to help in setting up that program.

There is only one other point I want to cover. I think from the clinical point of view the inclination on the part of the hospital physicians is not to consider the diagnosis of influenza in mild upper respiratory conditions. The A strain of influenza produces a mild disease and even in our experience this year in the outbreak in California, the diagnosis of actual influenza was at least two weeks late because consideration was not given directly to the diagnosis of influenza. I would ask your cooperation in surveying very carefully each upper respiratory outbreak, and, if the rate is rising rather rapidly despite the mildness of the disease, we request that you have ward surgeons send in the specimens to the Army area laboratories, each of which has a virus section capable of diagnosing the disease. This is particularly important in isolating additional strains, because we don't know from what part of the country new strains present themselves. The virus sections of the laboratories are sending in specimens from all virus material to the Army Medical School virus laboratory for recheck. In addition to that, the Army Medical School forwards part to a strain center located in the laboratory of Dr. McGill in New York, who is highly expert in isolating and identifying new virus strains. The matter of sending prepared specimens to the laboratory is of great importance to us not only in the diagnosis of influenza in your own Area, but possibly in helping us to identify new strains that may influence component parts of our future vaccine.

U. CLINICAL PHOTOGRAPHIC LABORATORIES.....Dr. Edward M. Gunn, M.D.

General Armstrong, hospital commanders and Army surgeons, I'll speak on clinical photographic laboratories and the Army Medical Illustration Service. Today, medical illustration, defined in its broadest sense, is a necessary requirement and an integral part of any properly developed program concerned with medical practice, education, and research. The Army Medical Department has been a leader in this specialty field for many years--it has contributed substantially to the development and advancement of techniques in medical cinematography, photomicroscopy and color photography. It is our intention that its enviable position of prestige be not only maintained but furthered.

The Army Medical Illustration Service, an organic component of the Army Institute of Pathology, is charged with the responsibility of collecting medical illustration material and supervising clinical photography and medical arts for the Army. (AR 40-410, par 3e). Policies and procedures have been established and published relative to the operation of clinical photographic laboratories in general hospitals; hospitals authorized such laboratories have been designated; and authorized equipment and supply levels have been set forth. References to this are in SGO Circulars No. 75, 10 June 1947 and No. 129, 10 October 1947; and SGO Circular No. 2, 5 January 1948.

For your information, laboratories are presently authorized at the following general hospitals: Army & Navy, Wm. Beaumont, Brooke, Fitzsimons, Letterman, Madigan, McCormack, Murphy, Oliver, Percy Jones, Walter Reed, Tilton and Valley Forge, and a central laboratory is authorized for the Army Institute of Pathology.

This service activity is of great importance to every member of the Medical Department and to the Army. It should be a source of considerable pride for all of you to know that members of the medical profession and of allied scientific fields from all parts of the world correspond with and visit the Army Institute of Pathology to secure information and material for which it is recognized as being the outstanding source. You no doubt will also be interested to learn that the film loan program, which has recently been decentralized to the control of Army Surgeons for the local professional benefits to be derived therefrom, has grown from nothingness in about eighteen months to the point where there are now approximately 2,000 names on an approved mailing list of unsolicited extra-military users. PMS&T's at several of the medical ROTC units are already taking advantage of the resources to be found in this central facility.

These few facts certainly demonstrate the tremendous opportunity which exists for disseminating information in a discrete manner to those of the professional and allied scientific fields, whom the Medical Department wishes to impress favorably with the high standards adhered to in the service. From recent experience I am convinced that

there is relatively little known by the military of these facilities which exist for its benefit. It is sincerely hoped that you will add this information to your armamentarium.

A large central library of documented medical illustrations consisting of case entities and medical subjects is maintained by the Army Medical Illustration Service, at the Institute. The documented illustrations in this library, which are collected from the aforementioned clinical photographic laboratories at the general hospitals, the Army Institute of Pathology, and many other sources, are for the use of the entire military establishment wherever and whenever needed. Such materials may also be made available to other federal agencies, civilian teaching institutions, hospitals, and qualified civilian scientists for study, research, teaching, and preparation of medical publications, under such policies as may be established by The Surgeon General.

The standard operating procedures for these laboratories described in the recent SGO Circular No. 2, 5 January 1948, are intended to facilitate the collection and classification of illustration material at contributing sources; to facilitate its transmittal to the Army Institute of Pathology; and to facilitate correlation with the central files of the Army Medical Illustration Service. Certain factors covered in the circular are distinctly new and rather definite--all are based on lessons learned during the past, World War II, and the post-war period. The "why" behind some of the newer details is naturally not included in the directive, however, it has been suggested that you should be informed, hence I make reference to a statement that reads to the effect--"All clinical photography and medical arts produced by and for the Army Medical Department is the property of the United States Government and is subject to the restrictions and regulations pertaining thereto." Such statement is enunciated and emphasized to forestall any future unpleasant incidents. I believe you all have at least heard of this regulation being violated. Frankly much valuable material has been lost by the Medical Department to individual collectors. Further, it is stated--"No clinical photography is authorized without prior completion of a request slip and a release form in duplicate." This serves your interest, since the review of the slips by you or anyone else will show exactly the type and amount of photography being accomplished and they will substantiate the required requisitions and reports. The release form will help to protect the Army and those individuals, who display photographs at a later date, against legal suits from those pictured, who feel their rights of privacy have been violated.

Further, a case or subject which warrants the use of color film is to be photographed twice. One original is retained by the contributing station and one is forwarded to the Army Medical Illustration Service. This action meets the needs of the station and also provides the original material required by the Army Medical Illustration Service to answer adequately all other requests.

Further, because of the basis upon which these laboratories are authorized, only the following categories of subject matter can be photographed: cases of unusual medical and surgical interest, occasional representative cases of ordinary or routine medical interest, new and unusual medical procedures and/or equipment, subjects requested by the Army Medical Illustration Service, new modifications of routine medical procedures, original medical research work and/or significant medical, statistical analyses, gross pathologic and anatomical specimens, and photomicrographs. May I invite your attention to the fact that so-called "legal," "public relations," "I&E," and other similar types of photographs are not included--a common error found in reports submitted to date. Please make certain the reports contain accurate figures and that they are for the approved medical categories only.

Further, it states--"All motion pictures will be photographed at sound speed, (24 frames per second). Immediately upon completion of the photographic assignment, all motion picture footage will be sent for processing and marked for return to the Chief, Army Medical Illustration Service, Army Institute of Pathology, Washington, D.C., where arrangements will be made for duplication, editing, and conversion of this footage into official Army films. A complete written description of subject material, contributing unit, cameraman, location, footage, date when film was taken, and descriptive scenario, including names of patients, names of medical officers, history of case and description of action will also be forwarded directly to the AMIS. A duplicate will be sent to the contributing station providing a request for such material is submitted to the Chief, Army Medical Illustration Service at the time the footage is sent to the laboratory for processing." These are basic principles of professional photography and are required by the Signal Corps. The color originals must not be projected (run), because the footage becomes scratched and permanently damaged with each running. The dupes are used for projection, editing, study, etc. The original is used only for final match cutting and then as the color master from which official Army release prints are produced. We will furnish the dupes to meet your early needs at the contributing stations and all footage which is photographed by the Army Medical Department is to be used ultimately as source material for the production of official films if it is approved as containing The Surgeon General's doctrine.

Lastly, there are now only two reports required, both are submitted quarterly. One, the Medical Illustration Quarterly Report, Reports Control Symbol MEDEM-96, a new form; the other, the Signal Corps Still Photographic Laboratories Production Report, W.D. AGO Form 11-18. The data submitted in these reports and that submitted in connection with supply requisitions should be correlated. To date, in most instances, any connection between them has been purely coincidental.

This presentation of facts is made to give you current information on a little-known but active and valuable Medical Department activity; to acquaint you with the need that exists for careful command supervision, rational utilization of facilities, and the efficient usage of scarce and valuable supplies; so that we may always justify beyond all question the photographic facilities. The Army Medical Illustration Service will exert every effort in your behalf, will assist your workers in overcoming technical problems, and will maintain training facilities to which you are invited to send one representative at a time for consultation and on-the-job training.

GENERAL ARMSTRONG: Thank you Doctor Gunn. I'd like to say that the work Dr. Gunn has done and is doing is deserving of the very highest praise. He is making a very, very fine contribution to the Medical Department.

V. PROGRESS IN THE DEVELOPMENT OF AIRBORNE HOSPITALS.....
Lt. Colonel Carlos F. Schuessler

General Armstrong, hospital commanders, and army surgeons. We appreciate the opportunity afforded us at this meeting to present some of our air force views and thoughts on light weight medical field equipment. General Grow has often pointed out to us that during the war the air force was frequently called on to transport gasoline, various supplies, and even evacuation hospitals from one spot to another. He also observed that it took a relatively large number of airplanes to do this, pointing out, for instance, that nineteen C-47's were required to transport one platoon of a field hospital at its present weight. About a year ago, the General charged the School of Aviation Medicine with the task of developing an airborne field hospital that could be easily and readily transported by air. Our first step was to have one platoon of a field hospital shipped to us; we noticed that the bill of lading indicated a weight of 60,000 pounds. After uncrating the numerous items and making an initial survey, we were convinced that radical revision would be required in making the assembly reasonably air transportable. With some thirty tons of hospital equipment at our disposal, we organized the undertaking into three phases to permit an intelligent approach to the problem. Phase one was designated the elimination phase; phase two, redesign or substitution; and phase three, packaging. We have practically completed phase one. To accomplish this, we laid the equipment out on tables in a large building and invited our staff, members of the Brooke General Hospital Staff, and civilian professional people who had wide experience during the war in field work, to indicate which items were, in their opinion, nonessential. To our amazement, a great many items were considered nonessential or obsolete; but at the same time a good many other items were recommended for inclusion, and in the end we found our list was more extensive than in the beginning. This didn't make us particularly unhappy in that we discovered a general interest in lighter components permitting us to make substitutions which would tend to reduce weight, yet permit satisfying individual idiosyncrasies. The suggestions served the further purpose of enabling us to select and redesign equipment in a manner to assure the end product being the best that could be devised for the purpose. We recognized the necessity for completeness, simplicity, and functional ability of the components to eliminate the need for improvisation by the ultimate using agency. Some of you may recall

that during the war it sometimes became necessary to improvise a table, etc., and when a move became necessary, your transportation problem had increased correspondingly.

We are presently engaged in phase two and three. The unnecessary items have been eliminated and we are now going over some of the heavier items such as beds, autoclaves, and operating room tables, and are redesigning them along aircraft construction lines. We are convinced that over-engineering should be avoided. If a bed, for instance, is to carry the weight of one or perhaps two men, we feel it a waste to construct it solidly enough to support a truck. We further feel that field equipment need not have a life expectancy of twenty years; this medieval thinking still plagues us in the form of World War I equipment which we still have in our stores. We have developed an operating room table which, with a packing container that serves as two instrument tables, weighs 32 pounds as compared with the present field operating room table weighing about 160 pounds or the latest Carlisle model that weighs 200 pounds. It has no fancy elevating gadgets, yet its design permits easy and ready lift to any of a variety of positions. In that way, we have eliminated considerable weight. We have used tubular construction, magnesium, and aluminum and believe we have a fairly serviceable, light weight operating room table. We have several of the items on exhibit here and will appreciate your examining and criticizing them, giving your frank opinions.

In establishing the characteristics of an airborne hospital, we emphasize certain specific features. The first of these is lightness; it must further be made up of small units that can be expanded; for instance, the laboratory equipment is contained in one chest, designed for use in a dispensary or a small hospital; its adaptation to a large hospital would require only an additional supplemental chest. Ward equipment will be similarly designed and packaged—the basic ward equipment being contained in a minimum number of standardized containers. A surgical ward would be readily available by addition of a supplemental chest. As previously indicated, this hospital must be functional and not dependent on the ingenuity of the staff for workability and adaptability. We propose to design all containers to serve as furniture upon being emptied. We illustrate this with some of the chests on display here. We, of course, propose to include the latest developments in medical equipment. This, we feel, is essential. Our largest problems center around the really heavy items such as electrical generators, housing, laundries, etc., which may be the responsibility of another agency or technical service. These items are necessarily bulky and heavy; however, it is our feeling that considerable reduction in weight can be effected. We would like very much

to develop some of these things ourselves, but are, of course, unauthorized to enter these fields; consequently, our recommendations will be submitted to the proper agencies.

We feel that adoption of 400 cycle electrical current for field use would be a definite advantage. By using 110 volts with 400 cycles, weights can be cut three-fourths. A quarter horse motor of the conventional type, for instance, weighs approximately 32 pounds; a comparable 400 cycle motor weighs 9 pounds and is equally or more efficient. We feel this is a field worthy of serious consideration. Since most units furnish their own electricity, we feel a conversion to 400 cycles has definite merit. Incidentally, such a change-over would affect only motors and transformers and has no effect on light bulbs, toasters, sterilizers, etc. X-ray equipment would require redesign.

In thinking of an airborne hospital, we feel that the aviation industry is in a good position to render valuable service by virtue of their knowledge of light metals. Their years of experience in air-lift problems especially qualifies them to develop light weight yet durable equipment. The feasibility of letting a contract to an airplace manufacturer to produce a prototype of an airborne hospital, strikes us as having considerable merit. We feel that in this manner the present 75-bed field hospital could be redesigned to permit its air carriage to a theater with a few modern cargo planes, rather than 19. I am sure there is little doubt in anyone's mind that in a future war, the airplace will afford a prime transport medium. As a result, the factor of weight and cube will be of great importance. Our aim, as far as medical equipment is concerned, is to keep both weights and cubages to an absolute minimum without sacrificing efficiency. The airplane manufacturer certainly can give good advice and service toward that end.

I could continue at length on this airborne field Hospital; however, I feel that I shouldn't take up more of your time and think we could put our point over to you a little better by actually examining the exhibits. You will notice we have a hospital bed--an ordinary ward bed--that weighs approximately the same as the old Army folding canvas cot; its advantages over a cot should be readily apparent. We have a fracture bed which weighs a pound more than the old Army cot. Since I am a dentist, I naturally devoted extra effort to the dental equipment. You will see that the method of packaging we propose to adopt for this whole hospital is a functional method whereby the things needed first are on top, things used less often are down at the bottom, etc. You also will notice that the method of packing assures orderly arrival at the ultimate destination. Repacking is also greatly simplified.

GENERAL ARMSTRONG: Thank you very much Colonel Scheussler. I could sit for hours and listen to the Chief Surgeon of the Air Forces and his ideas on how we are going to avoid the great wastage of time and medical personnel in the future. I find that he and his assistants, like Colonel Scheussler, are just about two jumps and ten years ahead of the rest of us in his and their thinking. I think it would be remiss on my part if I didn't ask General Grow to make some brief comments on this picture.

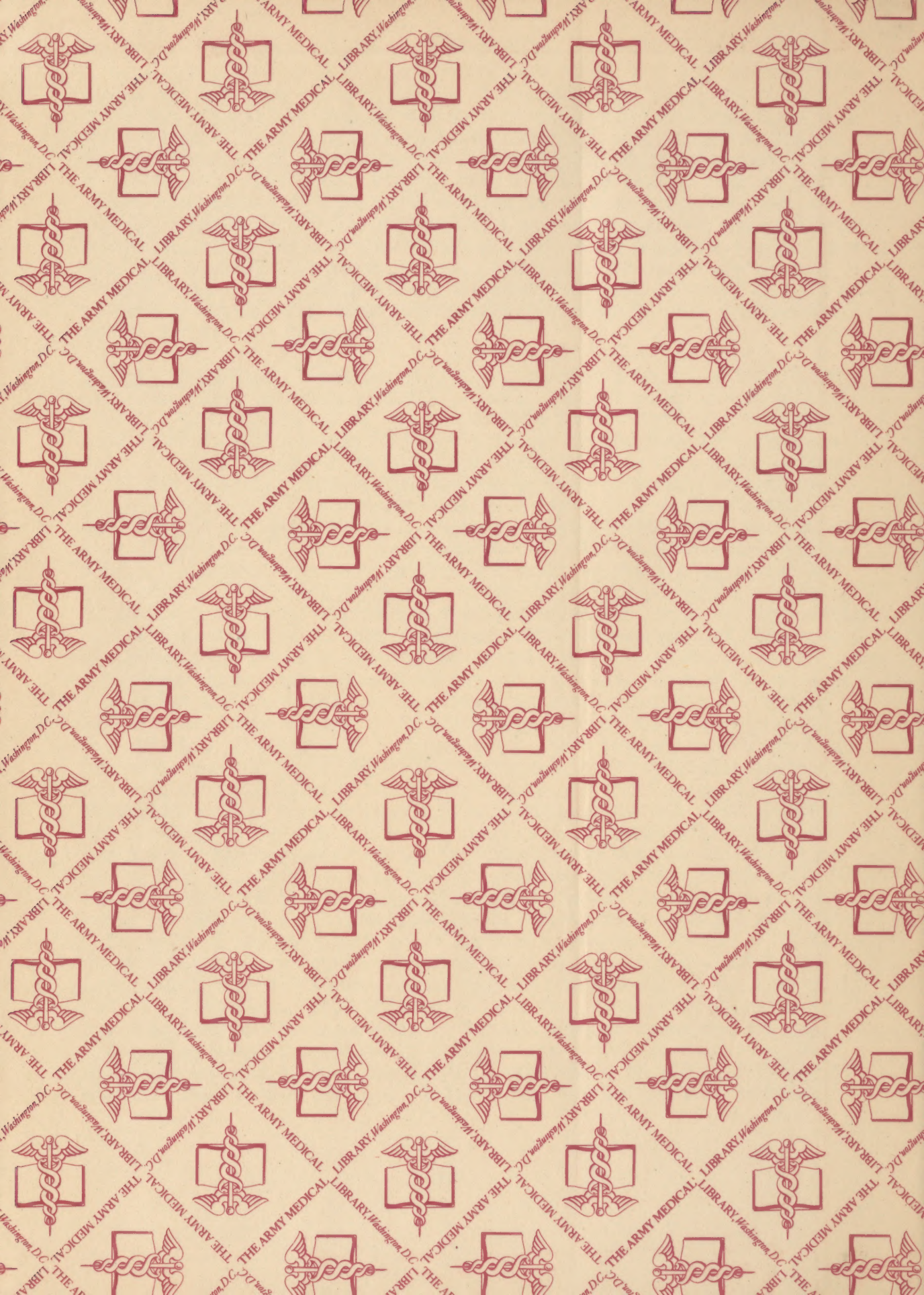
GENERAL GROW: First of all I want to express appreciation for the enthusiastic and fine work which Colonel Scheussler has done.

I started on this thing without any particular authority for research and design. I thought we would work on a few little medical items and see how we made out and I got a little research money which I could use. I looked around for somebody with a gadgeteer complex. Someone said that this fellow Scheussler had it. It was difficult for him, being a dental officer, to know exactly what the medical service required. So I thought that by starting this thing at the school we would have the advantage of the Brooks Field Staff to advise us along these lines. I want to again emphasize the fact that the aircraft people have been a lot of help to us. They have struggled, and you'd scarcely realize, unless you were close to aviation engineering, the great stress that has been put on them by the aircraft designers to cut wastes. That same stress is put on the Signal Corps in putting in various types of signal equipment, on the Ordnance, etc. Things are figured down to ounces and all of that goes into the ultimate performance of the aircraft. For these reasons I felt that in our first approach possibly the aviation industry would be better equipped with their engineering staffs to tackle these problems of engineering in the light weight metals.

As the thing went on, as Colonel Scheussler said, I got into items which were not my business but the business of engineering, and it is now a bit difficult to get the whole thing coordinated. It is also quite an expensive project, and I don't know how I am going to carry on from this point—when I get into such things as dishwashing machines, sterilizers, and items of heavy equipment. We have all of the Technical Services mixed up in this project and so I brought some of them into my office and discussed these things with them. I can now see where we are up against a bit of a block. I can also see where we are going to need a little bit of help from The Surgeon General's office. The Marine Corps and Navy are very much interested in this project from a standpoint of amphibious operations. Maybe by getting everybody together and in back of us perhaps we can put it across. The Air Corps is interested first of all from a standpoint of medical service; secondly, it is interested because it decreases the demands for cargo aircraft. I think some of you who were in ETO will remember when General Patton was up across the Rhine; the bridges were down; the railroads were out; it was very difficult to

supply him with gasoline, ammunition and food. So the Troop Carrier Command was called upon in a period when they were not getting Air Force troops and they did quite a big job of resupplying. Well, about that time, the boys in the Army wanted to move an evacuation hospital too big for a troop carrier. It was pretty evident that that equipment was very heavy and very difficult to move and so that was the double-edged sword of helping the Air Force a bit and also I believe it will help us in any future operations; so I received support on this project from the Air Force. I think I can visualize the next war as anyone can and especially you people who were in the Southwest Pacific where you were jumping from island to island. I believe you will admit that if we can reduce the overall weight and construct this airborne equipment in a way that it can be quickly set up with things available, I believe it is a worth-while effort for the men in the field.

GENERAL ARMSTRONG: Thank you very much, General Grow. I believe that that takes care of all the formal papers. I'm not going to sum up this meeting, with any degree of detail, because in the first place, I'm not capable of it and secondly we haven't time. I'm certain that everyone here has other things which they would like to bring out, but I believe it is not feasible. I know that we deeply appreciate your coming, and the enthusiasm and patience that you have exhibited. I feel certain that we will all gain from this meeting. When we will have the next one I am not prepared to say. I suspect that it will be in November of this year. The reason I say that is that I'm going to put a plug in for the Association of Military Surgeons. Those of you who attended the meeting in Boston last fall, I think had the idea correctly, that the Association of Military Surgeons has had a rebirth. There were over 600 registered. The attendance was excellent and it is felt by the present officers, that probably, and the announcement is not yet official, in view of the fact that since there has not been a meeting of the Association for a long time in the southwest part of the country the next meeting will be in San Antonio. I don't want to be quoted on that because it has not been offically announced. A suggestion was made-and I'm not sure whether it was made by General Grow, General Hawley or who it was--the idea was that from time to time various people have meetings. General Grow probably has meetings of his key surgeons, we have meetings such as this, Admiral Swanson has his meetings and the Director of the Medical Department of the VA has his. Now the idea is that next year the chiefs will plan meetings of this sort so that they will be held at San Antonio either just prior or just after the date set for the Association of Military Surgeons which will in itself give a great impetus to the next meeting. If it is at at San Antonio we can take advantage of Brooke Army Medical Center and the general hospital in the center and Randolph Field. I think we could put on a good show. I'll collect on that from brother Hume who is the new president of the Association. I would like to emphasize the invitation of Colonel Scheussler; I think that no one in this room, with exception perhaps some of the clerical personnel, should miss seeing the exhibit after we are through. Colonel Duke has an analysis to make.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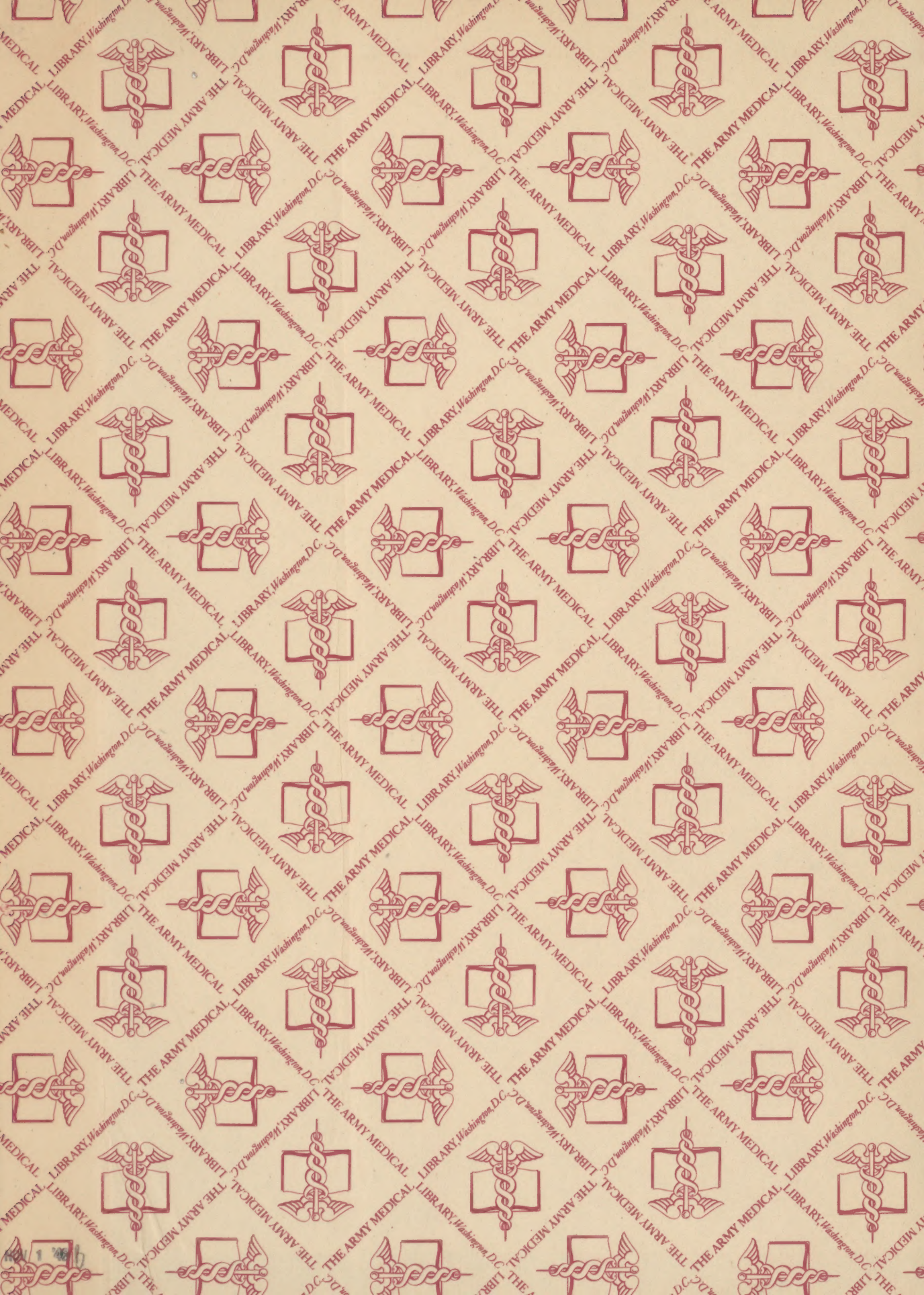
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